ARTICULATING THE WORK EXPERIENCES OF CHIEF MEDICAL OFFICERS: A QUALITATIVE STUDY

A Dissertation

by

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ABSTRACT

The contention between physicians and administrators in U.S. hospital systems has never been as divergent as it is today. The reasons for this conflict are found in historical and contemporary literature stemming from differences in group beliefs, variability of professional goals, and changes in recent healthcare policies and directives in this country. For the U.S. healthcare system to flourish amid these noted challenges, hospital system leaders must focus on the physician and administrator group differences and conflicts toward more group interdependence and balance. In my dissertation, the chief medical officer (CMO) is introduced and empirically studied as the linchpin of group cohesion and as someone who is vitally important to 21st-century healthcare and hospital systems.

Current literature regarding CMO practice provides limited insight on the position. Therefore, I engaged a qualitative methodology and design to better understand CMOs in a particular healthcare system. The case study design helped capture the findings that suggest that current literature falls short of discussing and fostering the processes by which CMOs perform their job. Thus, I engaged a new process-centric view in order to better understand CMO practice.

Through interviewing a select group of CMOs, my findings revealed that this unique group of physician leaders faced practical challenges regarding definition of their role, building and maintaining credibility with their physician colleagues, and development of the position. By bringing these issues to the forefront empirically, I

discovered the challenging reality of my participants through their experiences as translators, advocates, aligners, and protectors of their patients, colleagues, hospitals, and, ultimately, the healthcare system. Overall, the experiences of my participants fostered the creation of implications for research, practice, and future studies regarding performance of the CMO position in support of U.S. healthcare system goals.

DEDICATION

I dedicate this dissertation to my wife and children. Their continued support and understanding throughout the research process was fundamental to my accomplishing this career milestone. My love for them is immeasurable, and I thank them for supporting my dream. Debbie, Justin, and Sarah, you are my everything.

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CHAPTER I

INTRODUCTION

A divergence of the clinical and the administration cultures in healthcare institutions in the United States may be undermining the quality of care patients receive (Numerato, Salvatore, & Fattore, 2012). Unprecedented national policy changes continue to foster a business orientation that controls patient care directives and resource allocation within and among hospitals (Arroliga, Huber, Myers, Dieckert, & Wesson, 2014; Lee & Cosgrove, 2014; Lee & Hall, 2010). The resultant view of patient care differs relative to value and cost of care.

Central to the physician and administrator's widening cultural gap are the dynamic national policy changes, which over time in the United States have furthered the dominance of medical business models over variations in patient care practices (Bujak, 1998). Thus, the evolution of a business mentality applied to healthcare, both in the United States and abroad, threatens continued expansion of the gap through the loss of physician power and autonomy (Numerato et al., 2012). Consequently, the work of physicians trained to ease patient suffering through individual patient care is under siege (LeTourneau, 2004; LeTourneau & Curry, 1997).

Conversely, administrators in U.S. healthcare systems must confront the challenges of healthcare policy changes in patient care and keep business units' solvent while at the same time partnering with physicians disgruntled by the changes (Lee & Cosgrove, 2014). The emerging solution involves a leadership position held by

physicians with business aptitude that is called on by healthcare and hospital systems to help foster a connection between the administration and physician divide (Sonnenberg, 2015).

Currently, a leadership position exists under the broader category of the *physician executive* but not in a hierarchical, leader-member leadership role (Cors, 2009; Runy, 2009). This leader is commonly called the *chief medical officer* (CMO). The CMO position calls for leadership practices that uniquely foster a balance between the physician and administrator work processes in a manner that knits the two together without favoring or denying one or the other. Thus, the CMO must "balance the *New England Journal of Medicine* with the *Wall Street Journal*" (Cors, 2009, p. 60) and speak the language of the executive boardroom *and* the medical staff lounge.

My dissertation focuses on the unique role of the chief medical officer as the physician leader who is taxed with bringing together physicians and administrators. The way the CMO performs the position is not based on a leader-follower, hierarchical paradigm. Indeed, this role is quite different in practice from other physician leadership positions found in today's healthcare. Although current studies are informative about the traditional leadership perspective, literature lacks sufficient insight regarding definition and practices of the CMO position (Fernandez, 2003; Runy, 2009; Sonnenberg, 2015).

This chapter offers several sections to begin the journey of understanding the role of CMOs in a U.S. healthcare system. The sections include the problem statement introducing the physician and healthcare administration cultural divide and the CMO as a special case of a physician leader taxed with spanning the two cultures (Fernandez,

2003). The purpose and significance of the study display how the role of the CMO is defined differently from that of other leaders in the construction of mutual cultural understanding, respect, and relevance in the current U.S. healthcare system. The research questions provided alongside the purpose of my project represent my interest in exploring the role of CMOs as a process that requires further understanding.

Additionally, I discuss the CMO position using one alternative theoretical framework, relational leadership theory, as a more appropriate view when uncovering the issues they face. Thus, my initial theoretical framework provides a scaffold for exploring and understanding the work of CMOs using a case study design. To set the stage for my research process, a brief overview regarding my methodology and design is provided at the end of the chapter.

Statement of the Problem

The continued business approach to healthcare simultaneously focuses on a cost controlled, team-based, and value-centered healthcare system (Lee & Cosgrove, 2014). This has led to misunderstandings, misinformation, and negative rhetoric between the two cultures (MacLeod, 2012). The resultant negativity ultimately threatens the goal of healthcare systems, which is the betterment of patient and community wellbeing (Cors, 2009; Runy, 2009). The following offers an introduction to the background of both physicians and administrators in the U.S. healthcare system.

Physician Practice

Historically, physicians have been trained and have practiced as autonomous champions for easing patient suffering through research and treatment of disease

(Larkin, 2012). Their training focuses on the importance of patient care irrespective of cost or resource availability and the expectation that patient problems have solutions (MacLeod, 2012). Physicians in the current U.S. healthcare system emphatically protect their individuality and autonomy in clinical practice. The historical and current U.S. physician practice paradigm toward patient care, though, is quite ambivalent toward system cost and resource availability (MacLeod, 2012).

Furthermore, the antiquated physician mindset of care over cost is antithetical to the focus of managerial work (administrative practice). Hospital administrations must consider primary team-based strategy development, management of interprofessional patient and community care, resource allocation, cost containment, and performance measures. These administrative characteristics and processes are set up to improve revenue streams and support positive budgetary outlays (Duffy, 2014; Lee & Hall, 2010; LeTourneau, 2004).

The ethos of medicine, which is the crux of physician practice, is vital to the care of patients, the research for new treatments, and the curing of disease. This ethos also defines an identity consistent with an emphasis on patient care and not on the healthcare system, the hospital, or solvency (Peirce, 2000). Interestingly, physicians are the only ones able to admit patients for treatment within hospitals. As such, they enjoy a certain amount of power regarding patient care over revenue generation for hospitals. They struggle, though, to maintain their identity among the tide of national policy changes (Smith, 2014).

Healthcare Administration Practice

Healthcare system administrators, conversely, are more familiar with how to run the business of patient care. They understand the importance of strategy, risk management, and resource allocation central to organizational success of the system (LeTourneau & Curry, 1997; Peirce, 2000). However, they struggle to overcome resistance (Bratton, 2011; Cors, 2009) and garner buy-in from the medical staff (Edwards, 2005; Gomez, 2013). Consequently, the leadership embedded within the administration of hospitals views physicians as roadblocks to care (Garelick & Fagin, 2005; Ireri, Walshe, Benson, & Mwanthi, 2011; MacLeod, 2012).

To shrink the expanding clinical and business divide, hospital and healthcare systems have turned to the integration of the CMO into the executive suite at local, regional, and national levels. Historically, CMOs consisted of older, well-respected physicians within a hospital community on the cusp of retirement (Bratton, 2011). They were individuals identified as advocates and liaisons for purposes of conflict resolution, policy support, and practitioner credentialing (Sonnenberg, 2015). Additionally, their training for the position was on the job, commonly supplemented by leadership and management curricula (Cors, 2009).

Chief Medical Officer

The chief medical officer, in the evolving U.S. healthcare paradigm, is becoming much more than a voice for physicians who must contend with medicine as a business. Instead, these leaders are cultivators of dynamic relations who are conducive to the mutual success of both physicians and hospital administrators (Bratton, 2011;

Sonnenberg, 2015). Accordingly, the social and interpersonal processes that are occurring between these two relevant groups requires further research that could better inform CMO practice.

A unique physician leader. The changes in healthcare demand a more systems-oriented approach that fosters the role of the physician leader as a cross between clinician and administrator (Lee & Hall, 2010). The chief medical officer is identified as the only physician leader able to represent both physician colleagues and administration within the system (Bratton, 2011). Consequently, they are considered experts with aptitude in understanding both medical and management practice, are nested within the executive suite, and are commonly employed by healthcare hospital systems (Larkin, 2012; Longnecker, Patton, & Dickler, 2007; Runy, 2009).

The CMO position, as exclusively filled by a physician, has been discussed in literature both inside and outside the United States (Larkin, 2012; Longnecker et al., 2007). They are reported to be translators (Sonnenberg, 2015), mentors (Spehar, Frich, & Kjekshus, 2012), hybrid managers (Joffe & MacKenzie-Davey, 2012), influencers (Gabel, 2012), team builders (Runy, 2009), and advisors (Jakubowski, Hartin-Moreno, & McKee, 2010). As an intricate part of healthcare systems, such discussions advocate for communication and strategy supportive of the primary system goals, which in turn lead to exemplary patient care produced by both the clinical and managerial cultures (Apple, 2014; McAlearney, Fisher, Heiser, Robbins, & Kelleher, 2005; Reynolds, 2011). Unfortunately, the CMO position lacks empirical guidance regarding practical work processes and connections to performance in the position.

An evolving position. The CMO position has now evolved to become more commonly engaged in both overall organizational strategy and micro-level intergroup processes and behaviors. This evolution challenges the traditional role of the CMO and the theoretical foundations used to understand them. Today, the CMO lives in between the practice and the business of medicine yet is embodied within the social identity of physicians as the *in-group* representative (Hirschfeld & Moss, 2011; LeTourneau & Curry, 1997). In addition to their representation of the in-group, they are also responsible for the needs and mission of the hospital as an *out-group* member of the executive suite.

The CMO, as a leader in between and across both mediums, is engaged in a process of constructing and negotiating group relationships. On one side, the CMO is a physician practitioner who is administrating, and on the other side, he or she is an administrator practicing medicine (Cors, 2009). This results in the CMO standing "precariously with one foot firmly planted on each side of the fence. The delicate nature of this position can lead to splinters in some sensitive areas" (Myers, 2013, para. 10).

Understanding the position. Guidance regarding definitions and challenges to the specific and important CMO position are found in physician leadership and healthcare management literature, both empirical and theoretical, as well as in firsthand CMO interviews and trade journal positions (Bratton, 2011; Cors, 2009; Fernandez, 2003; Larkin, 2012; Runy, 2009; Sonnenberg, 2015). Historic and contemporary thought provides limited insight discussing and arguing CMO roles and responsibilities, competencies, training goals, and integration of cultures from traditional leadership

perspectives (Sonnenberg, 2015). Such articles offer critical, individual-oriented insight for effective leadership development and practice (Lewis, 2013).

However, reaching beyond contemporary research regarding leader-centered approaches to physician leadership unveils a potential alternative to understanding the CMO position. Theoretical frameworks that focus on the process of leading are available but are untested in healthcare. An alternative lens could view the role of the CMO as a process that fosters a supportive and synergistic physician/administrator relationship instead of adversarial.

Unfortunately, as noted, there is a void in physician leadership research regarding a line of inquiry specific to how CMOs exist within, relate to, and lead across two groups. Because both groups are characterized by the belief that they have equal power and importance in the current U.S. health system, little is known of the struggles the CMO experiences or how he or she manages them. The traditional leadership paradigms applied to CMOs offer only a clarification of leader type and leadership style, primarily as conduits of knowledge (Longnecker et al., 2007). It is important to see the role of CMOs as a process of leading both groups toward successful patient care and system solvency. Indeed, the lack of empirical and theoretical studies directed toward a process-oriented lens negatively leaves a significant view of CMOs open to unfounded and rhetorical interpretations.

Purpose of the Study

The purpose of this study, which used a qualitative methodology and design, was to explore the experiences of chief medical officers employed by hospitals within a south

western U.S. healthcare system in their emerging role as physician leaders working with both the physician staff and hospital administrators. It was also the purpose of this study to discover and better understand issues faced by CMOs that affect their performance in this unique role.

Research Questions

The following research questions guided this study:

- What are the experiences of CMOs as healthcare system hospital employees?
    - How do they define the role?
    - How do they succeed in the role?
    - How do they learn to perform the role?
- What are the primary issues faced by CMOs and how do these issues affect their ability to perform the CMO job?

Significance of the Study

The importance of understanding and guiding physician leaders within the U.S. healthcare system has never been more salient (Arroliga et al., 2014). The work of the chief medical officers, as the leader relating to both administration and medical staff within healthcare systems, is central to the system's success in contending with unprecedented healthcare growth and policy changes (Kaissi, 2005). My study posits that CMOs are in the vital yet tenuous position of having to bring together the business of medicine and the practice of medicine. Additionally, this study suggests that issues residing within the space between the two cultures must be resolved in order to move the U.S. healthcare system forward.

Issues such as the balance of power, autonomy, and interdependency between groups have been studied in other areas (Pittinsky, 2009). They have not yet been explored as a guide toward the work of and issues confronting CMOs. The limited understanding regarding issues confronting CMOs continues to threaten an already widening healthcare group chasm (Lee & Cosgrove, 2014; MacLeod, 2012). Consequently, the unidentified, or poorly defined, differences in values and goals between physician and administrators are incredibly profound but must be dealt with to meet the demands of modern U.S healthcare systems (Cinaroglu, 2015).

Current literature covers quite eloquently physician leader and leadership development from a linear perspective within the areas of management and psychology. The field of physician leadership is heavy with leader-centered models, including transformational leadership (Benson, 2016), servant leadership (Anderson, 2003), and participatory leadership (Slockett, 2012). However, what is now needed is an understanding of the role of the CMO beyond these traditional attitudes and recognition of what is happening within and through their specific experiences of leading.

My contention is that current research does not explore deeply enough the experiences of CMOs as nonlinear, nonhierarchical leaders. In addition, alternative theoretical lenses have not been explored in order to better understand the CMO's place in balancing two powerful healthcare groups or the processes engaged in weaving these groups together. Accordingly, my project endeavors to push beyond traditional leadership paradigms that come up short regarding the practicality of the CMO position.

Theoretical Framework

The use of theoretical frameworks is discussed by Anfara and Mertz (2014), who stated that qualitative studies use theory as a lens or a starting point to the research interest, thereby answering why the topic, or observation, is relevant. Merriam (2009) noted that theory is vital in qualitative research for orientation of the topic and underlies all research; in fact, without a theoretical rudder, the aim of the research might get lost. Maxwell (2013) stated that a theoretical framework informs the study design and provides the justification for pursuing the study. Finally, Schram (2006) suggested that theory positions the problem, purpose, and questions within a proven field of inquiry and knowledge, thus answering the question of importance and reasoning for the study. Consequently, a theoretical framework braces the components of my method, espousing the examination of participants in support of my research purpose and questions.

Many theoretical frameworks were available to me at the beginning of the dissertation process. As a student of human resource development (HRD), I drew on theories from areas outside of leadership yet still connected to the elements of my research purpose. Theories from organizational change and learning were considered early in the evolution of my dissertation but lacked adequate foundations to consider as central to the purpose of this project. Interestingly, the discoveries revealed in my findings' chapter supported a deeper look at organizational change and learning paradigms for the purposes of understanding the experiences of my participants more clearly.

Since my study focused on the experiences and activities of CMOs in a manner that was different from prior leader and leadership paradigms, I looked to a process-centric theory of leadership, such as relational leadership theory (RLT) by Uhl-Bien (2006), Uhl-Bien and Ospina (2012), and Crevani (2015), to begin the project. The core assumption of relational leadership theory is how leaders and leading emerge in everyday interactions. The process orientation is separate from leader-centered constructs by the absence of a linear, hierarchical pathway (Raelin, 2016). As noted, although other theoretical frames were discovered during the data analysis of my project, RLT appeared to be an appropriate starting point. Therefore, I introduce RLT next as a more realistic lens through which the experiences of CMOs were explored and understood.

Relational leadership theory is a process-oriented model that is socially influenced and presented as a contrast to other theories that focus on individual and leader-centered perspectives (Uhl-Bien, 2006). The main point of the theory is its focus on the practice of leaders and leadership that is socially constructed, interdependent, and intersubjective in the creation of meaning. RLT relies heavily on the recognition of a socially created construct, or space, that contains defined, yet negotiable, social contexts (Fairhurst & Uhl-Bien, 2012). Thus, RLT offers an assumption that leadership is recognized whenever it occurs and is not restricted to a certain leader type or trait (Hunt & Dodge, 2000).

The theory engages a constructivist ontology, which is a worldview of the practice of leadership as a series of interactions that build with each event and situation

(Crevani, 2015). The compounding of such interactions occurs in conversations every day and is centered on context (Fairhurst & Uhl-Bien, 2012). This worldview and framework allows for the creation of a socially constructed *space of meaning and action* that is both respectful of differences in values and power and is shaped and contoured specifically by its participants (Dachler & Hosking, 1995).

In summary, relational leadership theory views leaders engaged in the process of leading, which allows for the development of behaviors that construct and co-construct a social space of meaning and action with others (Crevani, 2015). It avoids identifying a specific leader type or trait by seeing leaders and leadership as (re)created in a dynamic context (Uhl-Bien & Ospina, 2012). Thus, the principles of RLT focus on ways in which leaders perform within an interdependent, process-oriented, and socially constructed manner (Uhl-Bien, 2006).

I began the dissertation using an alternative lens to view the work of CMOs that went beyond the identification of individual leaders' type and style. I integrated the process-oriented lens by questioning my participants as individuals who construct meaning from their experiences as connectors between two groups. Additionally, my lines of inquiry viewed the CMOs' role as a process and not specific to individual trait and style. This approach helped me understand better how they build relationships contextually within a very complex and shifting healthcare system. Accordingly, a process-oriented framework informed the purpose and research questions of my study and worked well as a starting point.

Methodology and Method

In this study, I sought to explore the experiences of CMOs, whose role is to bring together hospital physicians and administrators in a common goal—quality patient care. My participants consisted of a small group of specialized physician leaders performing the role of improving and protecting patients whose care is provided by a specific healthcare system. A qualitative case study was used to capture the unique CMO experience within a healthcare system and discover conditions and behaviors used to foster connectedness between physicians and administrators. The following provides a brief overview of both my methodology and method for this project.

Methodology

The methodology for my study was qualitative because I sought to develop, using inductive analysis, a deeper understanding of the experiences of my participants (Merriam & Tisdell, 2015). Attending to the experiences of my participants allowed for the exploration of the minute details of each within a social construction (Creswell, 2014). Additionally, my research included core assumptions of a theoretical framework in order to understand and evaluate these experiences in a natural setting (Creswell, 2013). Therefore, a qualitative methodology fit the overarching context of my dissertation, which was to discover, define, and understand a previously unexplored regional healthcare system and the experiences of specific physician leaders.

Method

A case study research design was used to understand the lived experiences of CMOs performing a vital role within a single healthcare system. The unit of analysis

defined the use of a case study (Merriam, 2002). Thus, the unit of analysis for my dissertation were the experiences of the CMOs through their reflections on the definition and meaning of their role working between two hospital groups. The qualitative case study fit my dissertation since I focused on CMO experiences bounded by the role they perform.. In this way, the case study design was appropriate as a means of describing and analyzing data from the participants.

Chapter Summary

Chapter I introduced the challenges embedded in the role of CMOs as they work between physicians and administrators. In comparison to other physician leaders within the hospital, the position of the CMO is unique and specifically placed in the hospital to bring groups together. The background practice issues revealed a prominence of historical divergence that confronts the CMO and that can be better understood through an alternative research approach not previously studied.

This chapter offered relational leadership theory as one way through which the experiences of CMOs could be better comprehended. Through an alternative theoretical lens, I posited that CMOs engaged in process-based leadership behaviors that create, strengthen, and capitalize on the important connections between their physician colleagues and hospital administrators. However, current scholarship engages leader-centered models when studying leadership in healthcare. Finally, I discovered that the processes engaged and the meanings found in the experiences of my participants revealed a need for an alternative view to better appreciate their day-to-day job

performance. The next chapter reviews relevant literature that informs the need for further research.

CHAPTER II

REVIEW OF LITERATURE

Introduction

The following literature review provides the background and support for this dissertation study. Several types of literature regarding physician leaders and leadership were sought to better understand the chief medical officer position. Although specific literature regarding CMOs is limited, research on physician leadership is more available. Accordingly, this review endeavored to highlight historical and contemporary studies, both empirical and theoretical, that discuss physician leaders and CMOs specifically.

The purpose of this study, which used a qualitative methodology and design, was to explore, the experiences of CMOs employed by hospitals within the Catholic Health Initiatives Texas Division in their emerging role as physician leaders working with both the physician staff and hospital administrators. It was also the purpose of this study to discover and better understand issues faced by CMOs that affect their performance in this unique role. The primary research questions included the following:

- What are the experiences of CMOs as healthcare system hospital employees?
    - How do they define the role?
    - How do they succeed in the role?
    - How do they learn to perform the role?
- What are the primary issues faced by CMOs and how do these issues affect their ability to perform the CMO job?

The historical background for the emerging role of CMOs is offered in this chapter. This background includes traditional theories that are leader-centered and linear, which have been used to help understand the position. Theories based on leader-centric behavior and style are abundant and reflect views and findings that are currently available in the literature to support and/or guide my research participants. Additionally, my review examines an alternative approach toward understanding physician leaders that contrasts with current empirical studies using leader-centered models directed toward these leaders (Fernandez, 2003; Longnecker et al., 2007; Myers, 2013).

The need for an alternative view regarding leaders and leadership in general is reinforced by the recent work by Gordon, Rees, Ker, and Cleland (2015). They contended that discrepancies exist in the application of traditional leadership paradigms to current healthcare systems. This viewpoint was used to aid in the exploration of an alternative framework, which helped make better meaning of the experiences of my participants. Specifically, my intention was that a deeper, more complete understanding of how CMOs perform their jobs would become evident.

The following literature search found that there is little offered to guide CMO practice. My review used a wide scope of key words related to my study, such as chief medical officers, physician leaders, leadership, healthcare, health systems, culture conflict, and leader performance. Several databases were used, including Google Scholar, PsycINFO, EBSCOhost, Sage Complete, Medline/PubMed, and Web of Science. The resulting collection of scholarly journal articles, non-peer-reviewed trade journal articles, and commentaries were dated from 15 years ago to the present. This

time frame for the articles allowed for a more contemporary collection of works that attempted to initially provide a baseline of guidance regarding the role of physician leaders. A more focused search of CMOs was then performed to tighten the literature findings. A limited number of international articles were included to reveal information about current physician leadership practice and additional historical background in other healthcare system cultures.

The chapter is divided into four sections; the first begins with a historical and contemporary overview of healthcare leadership specific to the group differences and divergence experienced by hospital-based physician leaders. Next, I explore physician leadership literature, which relies on leader-centered theories focused on dealing with this divergence. This section also discusses the need for a different way of viewing CMOs. Third, I explore my own experience as a medical practitioner and hospital leader in a healthcare system in order to identify gaps in the literature and reasoning for the consideration of other theories when viewing the role of the CMO as a connector. Finally, I offer a more in-depth discussion of an alternative theoretical framework, which I preliminarily felt provided a more completely understanding of the role of hospital CMOs.

Healthcare Leadership

The challenges facing physicians and hospital administrators in the United States are immense (Fernandez, 2003; Longnecker et al., 2007). The enormous and unprecedented shift in how healthcare is performed and paid for in this country culminates in significant cultural disparities, especially between the medical staff

(physicians) and executive suite (administrators) of hospitals within healthcare systems (MacLeod, 2012; Myers, 2013). Thus, my study focuses on a small group of specialized physician leaders to explore the ways they contend with living as both a physician and administrator.

To understand leadership in healthcare, a discussion regarding the rift between hospital physicians and administrators is offered from the literature, both in and outside the United States. First, a brief history provides the evolution and impact of the physician/administrator divide on the contemporary U.S. healthcare system. This includes support for the importance of recognizing and dealing with group differences that perpetrate the different values housed in a capitalistic healthcare system. Second, I discuss underlying power shifts and causes of resistance common to the experiences of my participants.

In the United States, the divide between business and medicine is quite extensive and dates to the late 19th century (Peirce, 2000). Through the decades of the 20th century, rifts surrounding the application of cost and resources toward patient care continued to fuel a divergent relationship between doctor and administrator cultures (Kaissi, 2005). Outside the United States, Edwards (2003, 2005) revealed a similar struggle within the manager/physician relationship in the United Kingdom. Specifically, the United Kingdom has found the cultural divide to be detrimental to quality patient and community care provided by the National Health Service (Edwards, 2003).

The turn of the 21st century brought additional compounding issues that expanded the divide between the practice and business of medicine, including new and

expensive treatment technologies and pharmaceuticals as well as improved patient engagement through readily available online information (Arroliga et al., 2014; Lee & Hall, 2010). These compounded to challenge the divide between patient demand and economic viability and availability, leading to further inflammation of the already deleterious feelings between doctors and hospital administrations. The foundations of the divide include the unique capitalistic healthcare system in the United States, the distinct differences between physicians and administrators' work processes, and a shift in the traditional balance between physicians and administrators found within U.S. hospitals.

In the United States, the early development of a capitalistic, or profit-driven, system purposefully separated physicians, administration within hospitals, and payers. This design perpetuated personal and professional scuffles over power, autonomy, and resources allocation (Peirce, 2000). Unfortunately, these areas of contention, elemental to the U.S. healthcare system, fostered a continual separation of physician and administrator power and independence. Not surprisingly, the resistance to changing roles and shifts in power worsened the relations between those most responsible for patient care (Lee & Hall, 2010; LeTourneau & Curry, 1997; MacLeod, 2012).

Understanding the gap between medicine and business, or physicians and administration, is significant. Fundamental to understanding the differences is the recognition of the core values of each. This includes knowing how each views the work they do and how they make meaning of positions taken to care for patients (Joffe & MacKenzie-Davey, 2012). One salient example is the interpretation of *worth*, which is found in the terms *quantity, efficiency*, and *accountability* for business, but those terms

are not applicable for physicians, in either practice or training, when defining worth. For physicians, conversely, the terms *patient advocate, curing disease,* and *autonomy* are central to the identity of the profession.

A profound example is the integration of the electronic medical record (EHR). The use of EHRs is mandated by U.S. healthcare policy in the Health Information Technology for Economic and Clinical Health Act (Health IT, 2014). The law, created to streamline physician and patient care work processes, has caused significant backlash from both physicians and nurses (Heath & Appan, 2014). The primary concern is an effect on autonomy of practice by clinicians and established patterns of care. Thus, one can see how physicians are adversely affected by the need to be strategic beyond the day-to-day work of patient care (Bujak, 1998; Lee & Hall, 2010; Myers, 2013).

The widening crevasse between the physician and administration underscored the need for physician leaders with the ability to weave the cultures together even though primary beliefs differed widely (Larkin, 2012). For example, physician leaders can help their colleagues focus on individual health within a hospital system. In contrast, hospital administrators can focus more on organizational health and viability, which includes the sustained ability to pay bills (MacLeod, 2012; Runy, 2009). Ultimately, irrespective of country, differences in how physicians and administrators view patient care perpetuate a cultural conflict that worsens the divergence of fundamental group values (Edwards, 2003; Edwards & Marshall, 2003; Möller & Kuntz, 2013).

Furthermore, the rhetoric involved in garnering position and influence within the groups themselves, along with their intragroup leaders, has played out negatively among

hospital leaders (Edwards, 2003). Cultural values are vital to the individual, though, since physicians and administrators are distinct yet polarizing groups. The dichotomy leads to more polarization and resistance, further arresting interdependence and synergy in the care of patients (Edwards, 2005; Sonnenberg, 2015).

The resolution of these differences, considered important toward the success of the U.S. healthcare system, requires attention (Peirce, 2000). What is missing is an understanding of the processes guiding physicians and administrators beyond leader-centric lenses. As the reduction of human suffering is the ultimate goal of any hospital system, a review of history reveals further explanation of the need for physician leaders and the work they perform.

An exploration of literature regarding the need for physician leadership and representation finds drastic healthcare changes in the 1980s and 1990s. During this time, an apparent need to understand the business of healthcare as a function of cost control and financial stability became prevalent (Lundberg, 2014). The rise of system mentality and community care payment models, such as HMOs as well as other insurance models, constrained physician practice behaviors in a top-down fashion, highlighting the need for physician representation within hospital systems (Peirce, 2000). This led to the institution of a new physician leader role that could create a means of aiding and guiding physician activities such that they matched the demands of payer organizations and management systems (Lee & Hall, 2010).

Historically, the physician practice has not been as business or politically perceptive as it should have been and has found itself shorted in the development of

healthcare policy within the United States (Lee & Cosgrove, 2014). The lack of business or organizational training in medical school and possibly the lack of interest on the part of the practitioners have led to less involvement in the business side of medicine. Nevertheless, administrator practice within hospitals is geared toward and trained in the management of growth of the healthcare system. Thus, administrators know intrinsically how to garner advantage regarding the most significant component for keeping hospitals solvent—the payment system (Menaker, 2009).

Changes in payer models and policy further perpetrated the shift of the relationships toward favorability of the business perspective centered on concern for hospital cost containment and efficient allocation of limited resources (Larkin, 2012; Lundberg, 2014; Martin & Quinn, 2013). The modification in how physicians and hospitals are paid engrossed the relationship and continued to diverge the drive to care for individual patients irrespective of cost or resources; hence, a reciprocal response by hospitals to maintain affordability and market viability was required since both were forced to live within service reimbursement models. Consequently, physicians within hospitals and part of larger healthcare systems could benefit from a physician leader able to help navigate policy changes (Garfield, 2015).

Physician Leadership

This section reveals relevant historical and contemporary discussions regarding the work of physician leaders between physicians and healthcare system administration both within the United States and internationally. Because literature is scarce regarding CMOs specifically, a wider search for relevant literature to better understand and guide

this group was required. The following section discusses three issues regarding CMO leadership: (a) the leader-centered approach used to guide physician leaders working between physicians and administrators is not sufficient to understand and guide CMO practice; (b) hierarchical and linear leadership models are not representative of the reality of the CMO position and fail to inform performance in the role; and (c) leadership training programs are limited to larger healthcare systems, underdeveloped relative to the realities of CMO practice, and not readily available. Each issue offers a window into the challenges of having limited research regarding the CMO position.

Leader-Centered Studies

My literature search regarding physician leadership reflected a predominance of an individualistic tactic, which is common to journals of management and leadership (Gabel, 2012; Menaker, 2009). Most identified articles reflected the inclusion of physician leadership within management and organizational models. The focus, though, was on individual leader traits, skills, roles, and actions that are common to contemporary leadership studies (Crevani, Lindgren, & Packendorff, 2010).

The work done by physician leaders who are both physicians and administrators is unique in healthcare as evidenced by the works of MacLeod (2012), Gabel (2012), Orlando and Haytaian (2012), and Menaker (2009). Each of these authors offered a different spin on the work of physician leaders in the evolving U.S. healthcare system. MacLeod (2012) used cultural competencies and cultural cultivation to help understand what traits may provide a smoother relationship between hospital physicians and administrative staff. Gabel (2012) looked to transformational leadership and influential

power to bring physicians together toward negotiating and maintaining their place in the healthcare system. Orlando and Haytaian (2012) discussed physician leadership relative to competencies and behaviors learned within the curriculum of a specific physician leadership institute. Finally, the work of Menaker (2009) revisited transformational leadership, which guides a set of behaviors conducive to change management through several changes in U.S. healthcare policies.

Unfortunately, these works are theoretical and not empirical, offering only propositions and assumptions about the changing environment within healthcare using traditional leadership models. Such changes are the driving force for more physicians to look differently at the larger picture beyond individual patient care (MacLeod, 2012). Thus, I was left feeling that physicians are looking for an individual who represents the physician's practice and has an aptitude for business to fulfill the role of CMO. Since empirical studies are lacking, little support is available to show that this is the case.

Hierarchy and Linear Leadership

Literature that focuses on physician leadership describes individuals who exist in many areas of healthcare systems, including leaders of the medical executive committee, department heads, and directors of hospital initiatives and/or service lines (Sonnenberg, 2015). Such individuals provide a readily available group of leaders with appropriate skills and traits who can translate organizational values and missions as a conduit for their constituents. This type of leadership is linear, meaning that new policies and/or directives flow from the top down.

Additional empirical studies by Longnecker et al. (2007), Xirasagar, Samuels, and Stoskopf (2005), and dissertations by Pregitzer (2014) and Fernandez (2003) support the role of physician leaders within linear, hierarchical models. However, the work of Chreim, Langley, Comeau-Vallée, Huq, and Reay (2013), in their recent study of interprofessional healthcare teams, suggests that linear, hierarchical leadership structures using leader-centric frameworks to guide physician leaders are less predictive of effectiveness.

In this study, which gives a voice to CMO experiences, I contend that the way they lead is not of the linear type. As discussed in my findings, they live within the hierarchical structure of the hospital and healthcare system but are not afforded similar authoritative, or positional, power. Instead, my participants must lead differently, which in the past has not been adequately understood in the context of the uniqueness of their position. Unfortunately, current literature focusing on leader- or linear-centered models does not fully grasp the experiences or intricacies of the position.

Training

Literature provides some insight regarding leadership training for physicians, both in medical school and after graduation. Interestingly, these articles focus primarily on leadership training through large healthcare systems—for example, the Cleveland Clinic Foundation (Lee & Cosgrove, 2014; Lee & Hall, 2010) and Kaiser Permanente (Crosson, 2003). Such training, though, is focused more on growing, as opposed to understanding, the role of physician leaders. Larger healthcare systems do this by selecting those physicians who appear to have the aptitude for and are driven by

institute-specific needs (Sherrill, 2005). This approach, however, appears to be centered on the physician partaking of training to become more business-like and less clinical concerning patient care practices.

Overall, important points are gleaned from leader-centered, hierarchical leadership literature, which highlights at least a robust attempt by scholars to understand the broad role of physician leaders in the changing U.S. healthcare environment (Apple, 2014; Dye, 2014). Researchers attempted to list and decipher roles, responsibilities, and competencies with and without theoretical frames. Additionally, some articles offer outlines regarding the differences in administrator and physician cultures by providing a setting to inform, train, and perform leadership functions (Lee & Cosgrove, 2014; Martin & Quinn, 2013; McAlearney et al., 2005; Orlando & Haytaian, 2012). Although informative, such papers are directed toward the general role of physician leaders in hospitals.

The literature is also quite scarce regarding training. As noted, there is discussion about how to train physician leaders but not CMOs specifically. Additionally, learning programs are limited in availability and have not been empirically studied. This reflects a clear deficit in both understanding this important position and training for it in modern U.S. healthcare. The following section introduces literature support for the role of chief medical officer, which was the focus of my project.

Chief Medical Officer

The primary focus of my dissertation study was the role of CMOs in a U.S. healthcare system. The CMO position has an interesting history that has evolved from its

beginning as a figurehead of the medical staff to now, when it has become a healthcare system strategic partner (Sonnenberg, 2015). The following section provides literature discussing the history and evolution of the CMO position. Since the amount of literature is limited, this section also groups and discusses each paper and reflects on the deficits in the current research, which leads me to offer my own observations of the CMO position and the need for further inquiry regarding how CMOs do their job.

History of the Position

The CMO position, as indicated by the exhaustive work of Peirce (2000), appears to have originated in the United Kingdom with the National Health Service and then found its way into the United States in the early 20th century, where they are depicted as being representatives of physician colleagues in relation to hospitals where they practiced. Hospital administrators and stakeholders initially identified and employed CMOs as senior physicians near the end of their careers. These CMOs, still enjoying well-established relationships with both the hospital administrators and the medical staff colleagues, provided an important pathway for communication (Sonnenberg, 2015). As a result, the position was often one of importance when working between the administrative and medical staff in a top-down business management and hospital/clinic credentialing role (Larkin, 2012).

Past Role

The CMOs of the past experienced much less of a demand regarding such issues as organization development or systems integration. Their role as CMO was also explicitly limited in scope and directed more toward social connections and respect of

peers rather than leadership aptitude (Peirce, 2000; Runy, 2009). Hence, the CMO position began an evolution as changes in healthcare prompted more systems orientation, and U.S. healthcare policy shifted from the traditional physician/administrator relationship of give and take toward one of team-based cooperation and future planning (Larkin, 2012).

The position of the CMO continued to evolve into a special case of the physician leader as someone beyond just being a figurehead of the medical staff (Longnecker et al., 2007). Instead, as discussed by Cors (2009), this individual physician, with leadership propensity, provided not only the voice of the medical staff in the corporate suite (C-suite) but also created the bridge between the system physicians and administrators. Additionally, Longnecker et al. (2007) found that the organizational structure of common healthcare systems placed the CMO in direct line with the CEO of the system, interacting with administration in a more robust and strategic way within the hospital and healthcare system than those listed as physician leaders. Ultimately, the job of the CMO was expanded to being a connector between administrator and physician worlds. The role could then interact, collaborate, and capitalize on the synergies found in both cultures, as noted by Fernandez (2003) and Lee and Hall (2010).

Current Role

The CMO position continues to move to a more bridging role between physicians and administrators, but challenges are surfacing as the result of this evolution. Nowill's (2011) case study involving the developing role of CMOs in freestanding hospitals found the following: (a) CMOs, as physicians, lacked training in the language of

business since it was not part of medical education; (b) the CMOs' ability to direct independent physician colleagues without authority, through policy, slowed any possible changes in how they treated patients; and (c) CMOs commonly found themselves in very difficult social situations. Consequently, Nowill's work revealed the lack of understanding, either empirically or theoretically, of how CMOs perform the job of bridging that is vital to the position.

Current Literature

Empirical and theoretical literature regarding the role of CMOs specifically is available within the lens of traditional models of leadership. Unfortunately, scholarship centered on CMOs in the United States is limited. My exhaustive search discovered very few empirical and theoretical works; the search also included few firsthand accounts, interviews, and trade journal papers. Because my collection of scholarly and nonscholarly articles is limited in scope regarding the role of the CMO, I offer my own observations of the position as prior empirical data. The following three categories cluster found articles that relate to the role of CMOs in the United States:

- Articles from a theoretical perspective offering a comprehensive view from the perspective of traditional leadership (Fernandez, 2003; Longnecker et al., 2007; Nowill, 2011; Reynolds, 2011).
- Articles offering firsthand, implicit knowledge as a CMO (Bratton, 2011) and interviews of CMOs offering information applicable to practice (Larkin, 2012; Myers, 2013).

- Two articles offering a comprehensive list of *must-have leadership skills* and the *right leadership skills* to include as part of the CMO position (Cors, 2009; Sonnenberg, 2015).

Each category above is discussed below; each paper is individually noted as it relates to the aim of my dissertation.

Theoretical. Fernandez's (2003) dissertation provides a very comprehensive picture regarding the theoretical foundation of the practice of CMOs working in the physician/administrator cultural gap. It highlights the individual perspective empowered by transformational leadership within the cultural divide but is not process based. The work by Longnecker et al. (2007) is very informative regarding the power of influence and the struggles with CMO effectiveness, but outside of the individual attributes, there is limited direction regarding the process of working between physician colleagues and the administrators.

The single clinic case study by Nowill (2011) offers experiential learning as the framework and expresses an aim to influence business curriculum for physicians and the discovery of learning events. The article introduces *boundary-spanning* pertinent to the CMO position but is not expounded on past a mention in the responses. Although this article is pertinent to recognizing the power of mentorship and on-the-job training, it does not use a process-oriented framework or expand on bridging as integral to the CMO position.

The work by Reynolds (2011) discusses expanding the role of the CMO as a new type of leader in the U.S. healthcare system. The paper focuses on the importance of

developing new knowledge and skills to meet the changing healthcare paradigm. The pathways presented in the paper include the use of graduate-level business degrees, such as a Master of Business Administration (MBA) or Master of Hospital Administration (MHA), and recommends that a CMO attain one. Overall, the paper calls for physician leaders to become more knowledgeable in business to help improve physician and hospital relations.

Firsthand account and interviews. A group of CMOs were interviewed by Larkin (2012) as part of a position paper. He offered grassroots advice for CMOs from those who have practice experience. However, the paper is not scholarly and only provides practical insight for the nuances of the position. Interestingly, it provides information helpful to understanding the position, which is wrought with challenges when working between physicians and administrators. Additionally, practical solutions are offered to guide new and seasoned CMOs in practice.

A paper by Bratton (2011) provides a first-person account of his experience as a CMO in a large Kentucky hospital system. The paper discusses lessons learned, which primarily involve acquisition of soft skills and learning to work with the administration of the hospital as a member of the executive suite. His paper provides a very practical guide for new and current CMOs. Although the paper is insightful for practice, it is neither empirical nor theoretical and not beneficial to understanding the process of leading in order to bridge the physician/administrator gap.

An article by Myers (2013) is an interview of a CMO from the Memorial Herman Medical Center in Houston, Texas. Like the paper by Bratton (2011), Myers'

paper provides firsthand knowledge of being a CMO in a large medical center/system. The interviewer is Dennis Kain, who is the CEO of a large recruiting firm. He uses semi-structured questions to gain insight into the history and role of CMOs in the United States. The participant provides relevant information regarding the challenges of CMO practice. This is not a scholarly paper but does touch upon the importance of working pragmatically to serve both the physician and administrator cultures.

Focused leadership skills. Papers by Cors (2009) and Sonnenberg (2015) very specifically address the roles and responsibilities of the CMO. They both recognize the unprecedented changes in healthcare and offer pertinent skills. The article by Sonnenberg (2015) uses a new model to situate the CMO near the CEO and discusses how the position comes with new relationships that improve organizational effectiveness. The article by Cors covers more general skills for CMOs placed in a precarious position between the medical staff and administration. Like Sonnenberg's conclusion, Cors argues that these skills must be acquired to be successful at the position. As noted above, both papers draw from traditional leadership theories to advise which skills will be more successful.

Researcher's Observations

My experience as a medical practitioner in the United States for the past 26 years has afforded me the unique opportunity to witness significant changes in the healthcare continuum and its effect on physicians as a culture. As the researcher of this qualitative, empirical study, I integrated my familiarity with the research into this study. Also, given my personal involvement in the profession, it was unlikely that I could divorce these

professional experiences from my desire to understand the topic and participants better (Guba & Lincoln, 1989). Instead, my professional standing and established networks within the healthcare system of study allowed me to fully develop the purpose of the study (Erlandson, Harris, Skipper, & Allen, 1993), gain access to the participants as an insider, and be more deliberate in the co-construction during the design process (Dwyer & Buckle, 2009; Holstein & Gubrium, 2003).

Since this group of physician leaders has not been widely studied, my professional experiences, which include observations of the CMO position in action, provided an additional personal account in support of the need for my study. As I have watched the role of the CMO shift from a translator of healthcare system policy to the medical staff to a developer, influencer, and facilitator of hospital policy, I am impressed with how very challenging and tenuous this role is. Quite literally, these individuals are taxed with having to live in two worlds simultaneously, wherein each provides unique desires, agendas, and ideas about what is best for the hospital, patients, and healthcare system.

Limitations of the literature. I see two limitations to the current literature concerning CMOs, which open the door to a better approach to understanding the position theoretically and empirically, as provided in chapter V. The first is a lack of scholarly articles regarding the process of bridging the physician and administrator gap. As noted, the action of bridging is elemental to the position, and the absence of a process-oriented models is profound. This has led to seeing prior and current leadership paradigms as either incomplete or inappropriate to guide the CMO position.

For example, using theoretical frameworks such as transformational leadership to inform which type of leadership as best for CMOs may not offer a complete view (Fernandez, 2003; Longnecker et al., 2007). Although such frameworks are instrumental in leader-follower relationships, they have not been studied, or replicated,regarding relationships between equal systems. Since the role of the CMO calls for them to be leaders of a relationship that is dynamic, it would be best served by theories that focus on processes over individuals.

The second limitation is a lack of micro-level guidance on how to perform the job as CMO. As noted in my literature search, firsthand accounts provide practical pathways to perform the job but are few and not scholarly. Since there is no guidance on how CMOs should perform the fundamental bridging component of their position, I have observed hospital board meetings where theCMO struggles to define their position further convincing me of the lack of understanding what they do in the role and its affecton performance.

A new lens. I am acutely aware of CMOs' frustrations, which results in my desire to introduce a different understanding directed toward the position of the CMO beyond current leader and leadership modes. I discovered that alternative theoretical approaches will provide better appreciation for the work my participants perform. An alternative lens views the process of CMO work as one that recognizes, structures, builds, and maintains connections between two very distinct groups in a U.S. hospital. Indeed, looking at the work of CMOs from a different perspective appeared appropriate, but it had not yet been studied within this specific group of physician leaders.

An Alternative Theory

The literature review uncovered several papers that reveal what is available to guide physician leaders. A multitude of theories offer understanding of type and style suggested for physician leaders and CMOs specifically. As noted, though, gaps exist in current thought that call for alternative constructs to be considered when studying CMOs. In that vein, I offer one theory that may provide a much-needed framework when exploring the experiences of CMOs. Thus, a thorough discussion of an alternative theory, relational leadership, and my rationale for this approach is provided.

Relational Leadership Theory

RLT underscores and informs the role of leaders through constructionist ontology, finding social experience to be intersubjective and a way of being through others (Cunliffe, 2011). The theory focuses on the process of leadership, or leader-in-action (Crevani, 2015). Importantly, the leader-in-action is contoured and grown through the interactions of leading the co-construction of a space of meaning and action (Dachler & Hosking, 1995).

The space of meaning and action consists of a place of shared understanding that can be physical and/or conceptual. The space is created and re-created in everyday conversations that are not one way, as found in entity-oriented leadership views (Crevani, 2015; Crevani et al., 2010). Instead, the space consists of many interactions of communication that are multi-vocal (Crevani, 2015). Thus, the focus is on the process of leading and leadership as being socially constructed (Dachler & Hosking, 1995; Uhl-

Bien, 2006), which constitutes meanings and actions that are both contestable and negotiable (Barge & Fairhurst, 2008).

On a micro-level, individuals within the space and alongside the leader interact to create meaning that makes sense of realities. This creative work fosters practices of interdependence by forging new connections, strengthening existing ones, and capitalizing on strong ones (Uhl-Bien & Ospina, 2012). This activity occurs within the space in ways that contract and expand understanding (Uhl-Bien, 2006; Uhl-Bien & Ospina, 2012). Therefore, the interaction of the participants is pertinent to how leaders shape and are shaped by the space as it develops over time (Dachler, 1992; Fairhurst & Uhl-Bien, 2012).

Rationale

The groundwork for pursuing an alternative lens in the study of the CMO position becomes evident since current literature is found to be lacking, or incomplete, when addressing the cultural divergence prominent in today's healthcare paradigm. Since the work of CMOs is not hierarchical or between leaders and followers, the use of an alternative approach for the exploration of their work as bridges is essential to understanding this unique position. The RLT lens offers that ability to see the CMO as not a leader over, but instead a leader within a contextual and socially constructed space. Thus, the RLT approach provided a more robust and realistic starting point to how CMOs work between hospital physicians and administrators.

Chapter Summary

Chapter II presented contemporary literature that supported the purpose of this dissertation study and explored the need to further understand the role of CMOs in the U.S. healthcare system. First, I introduced and discussed literature that shows the impact of the physician and hospital administrator culture gap and challenges placing physician leaders in the current healthcare paradigm. Second, I introduced the CMO as a unique physician leader within the hospital executive suite specifically taxed with working with hospital physicians and administrators. Third, I examined the empirical and theoretical studies, interviews, and firsthand studies that discussed roles and responsibilities of CMOs in the U.S healthcare system. Fourth, I offered my own assumptions and concerns regarding the limitations of my literature search as evidence. Fifth, I argued that the noted studies do not reflect what I was seeing in the experiences of CMOs in my study. Finally, I introduced and described the components of an alternative lens, relational leadership theory, which can provide a starting point to filling in the literature gap regarding CMOs. In the next chapter, I introduce and describe the methodology and design steps used to explore the experience of my participants.

CHAPTER III

METHODOLOGY

Introduction

This chapter describes the research process for this dissertation study. I used a qualitative methodology and design to capture and make meaning of the experiences of CMOs and how they view the position and their performance within the role. Such a methodology and design was amenable to gaining rich descriptions of experiences using a human instrument in an inductive manner.

The purpose of this study, which used a qualitative methodology and design, was to explore the experiences of chief medical officers employed by hospitals within a south central U.S. healthcare systemin their emerging role as physician leaders working with both the physician staff and hospital administrators. It was also the purpose of this study to discover and better understand issues faced by CMOs that affect their performance in this unique role. The research questions were as follows:

- What are the experiences of CMOs as healthcare system hospital employees?
    - How do they define the role?
    - How do they succeed in the role?
    - How do they learn to perform the role?
- What are the primary issues faced by CMOs and how do these issues affect their ability to perform the CMO job?

The sections in this chapter include an overview of my methodology and research design. First, the research methodology is defined and includes my worldview framework and rationale. Second, the chosen method is defined along with the rationale for its use in my study. Third, sections on sample selection, data collection, and data analysis underscore the design of my project. Fourth, a section on validity and reliability provides the methods used to achieve trustworthiness in my results. Finally, a section discusses researcher bias and assumptions for transparency of my subjectivity.

Research Methodology

The methodology for this dissertation study was qualitative. This approach is defined by the researcher's desire to understand an issue as the primary instrument in an inductive process, which results in a rich description of the findings (Merriam & Tisdell, 2015). The qualitative methodology is also explained as an exploration of meaning that is garnered from individuals or groups as a manner of discovery (Creswell, 2014). Thus, using a qualitative approach opens the study to a gathering of multiple voices and interpretations of its participants (Creswell, 2013). The following offers additional understandings of the qualitative approach that lead to the rationale for the use of this methodology in my dissertation.

Definition of Qualitative Methodology

The qualitative approach, or methodology, is commonly used to discover, explore, and draw out the essence of an event or phenomenon as experienced by an individual or group (Merriam & Tisdell, 2015). There are multiple interpretations of this definition but most adhere to the primary premise that the researcher, who is intimately

involved in the discovery, seeks an understanding of an event, phenomenon, and/or process through the understanding and meaning of the participant (Denzin & Lincoln, 1994). The differences between qualitative and quantitative methodologies are now discussed to the support the rationale for the methodology of this project.

Quantitative vs. qualitative. Quantitative methodology is a *positivistic* approach that seeks to understand a population of people, cultures, diseases, and the like, by analyzing samples of the population in a deductive manner. This is an approach that relies on experimental or quasi-experimental designs looking for cause and effect and/or comparisons between variables (Creswell, 2014). The quantitative researcher follows a linear, standardized process that defines the variables and hypothesis prior to data collection. The findings are then found to either agree or disagree with the hypothesis in a manner that can be generalized toward the population of interest (Roberts, 2010).

The choice between using a qualitative or quantitative approach in research is based heavily on the research purpose and questions (Creswell, 2013). Roberts (2010) stated that picking the methodology is based on the problem, purpose, theoretical frame, and type of data to be collected. It is also based on the availability and number of data points. For example, quantitative research requires a large amount of data to adequately analyze with statistical methods.

In qualitative research, the number of participants is based on factors relevant to the purpose. In other words, a reasonable sample for a case study could be four to five cases, or for an ethnographic study, 10 to 30 participants (Creswell, 2013, 2014; Merriam & Tisdell, 2015). Accordingly, the qualitative researcher approaches the

problem and purpose via a holistic approach in order to find the appropriate sample number (Merriam & Tisdell, 2015). Two additional differences between qualitative and quantitative research include the use of theory and the role of the researcher.

Theoretical framework. The use of a theoretical framework differs between qualitative and quantitative researcher. The qualitative researcher uses the theoretical framework as a scaffold and not a rigid construct (Anfara & Mertz, 2014). The data collected in qualitative research is rich with descriptions and meanings. In contrast, the quantitative researcher uses theory to derive hypotheses, leading to generalizations and causations. Thus, the theory anchors the experimentation (Roberts, 2010).

The researcher. The researcher's role in quantitative research is detached, objective, and external (Creswell, 2013). In this way, the researcher can better achieve the research goals, which objectively test the *why* of the *a priori* against theoretically based hypotheses (Creswell, 2014). The researcher is an observer but not a participant in the experiment. Hence, data are usually obtained in a variety of ways amicable to a detachment between the researcher and the object being researched. The data are also convertible to numerical form and analyzed using statistical inference (Creswell, 2013).

Furthermore, the quantitative researcher differs from the qualitative researcher relative to what is being sought. Quantitative research looks for relationships among variables, some of which can be manipulated within the experimental design (Schwandt, 2015). As noted, this deductive process is built on a fixed, predetermined design and not subject to changes during experimentation. In contrast, the qualitative approach places the researcher within the process and considers his or her presumptions, interests, and

understandings regarding what is being studied (Merriam & Tisdell, 2015). Ultimately, the methodological approach, whether quantitative, qualitative, or mixed methods, follows what the researcher desires to know (Creswell, 2014).

Qualitative research characteristics. For the researcher to discover an understanding, he or she must engage with the participant in the natural setting so that context of the discovery is richly displayed (Lincoln & Guba, 1985). The research is then performed inductively, meaning in a manner that supports an inductive analysis of the findings as they occur in a naturalistic setting (Hays & Singh, 2011). Although not exclusive to qualitative research, the use of inductive analysis simply implies that the researcher works from the data to build meaning (Schwandt, 2015). Consequently, a qualitative study provides a narrative of the event/phenomenon built from interviews, observations, and pertinent documents in the participant's own setting (Roberts, 2010). This offers data that are revealed in an unbridled way in a place that cannot be, nor is desired to be, controlled by the researcher (Lincoln & Guba, 1985).

Additional researchers contribute to the definition by describing qualitative studies as flexible and not deductive in their design (Creswell, 2014). Instead, they are iterative with the data to continually build upon new and deeper discoveries (Merriam, 2002). The utilization of a qualitative methodology permits a reflective course, which Roberts (2010) noted provides minute details of participant experiences in both a social and cultural structure. The social interaction can then be studied for intricacies that provide robust descriptions available for analysis (Agee, 2009).

Worldview framework. The qualitative research approach identifies the importance of co-creation, which views the significance of the research to both the researcher and the participants since all are affected (Flick, 2006; Lassiter, 2005). Therefore, the qualitative journey centers on a *constructionist* worldview and allows for the discovery of the construction and co-construction of meaning by both the researcher and participant (Creswell, 2014). The constructionist ultimately relies on the participants' interpretation of the experience as the voice of the study. In summary, Denzin and Lincoln (1994) stated that making meaning of participant's experience is the *a priori* of the research.

The worldview of the researcher underlines the methodology of the research design (Creswell, 2014). The assumptions nestled within the philosophical lens are researcher-centric, which guides the overall mindset of the project. Thus, the lens that I used to choose participants, collect data, and analyze the data hinged on the philosophical umbrella unique to me. The following reviews my philosophical approach to the dissertation and how my overall lens affected the methodology.

The use of a qualitative methodology lends itself to making an interpretive, inductive, and deep meaning of the lives of my study group (Merriam & Tisdell, 2015). Although quantitative lens can afford an understanding of the experiences of people though instruments that gather numbered data for statistical inference, my work is more interested in the individual experiences of not only the individual participant but the unique environment in which he or she works. Therefore, the constructionist

philosophical interpretation within a qualitative research frame fits more with my personal views.

The constructionist worldview encompasses basic assumptions more closely aligned to the purpose of my project. First, the experiences of participants are constructed as they live within the contextual experiences of certain situations, or events. Second, the experiences of the researcher are also included as the one who brings his or her own set of understandings to the issues. Consequently, both the researcher and the participants grow through the collection and analysis of data within the research-defined context (Creswell, 2014).

The constructionist viewpoint, commonly labeled *social constructionism*, utilizes the experiences of both the participant and researcher to paint a picture of a specific *context* (Creswell, 2013). From the researcher-defined context, clues and cues can be gleaned and analyzed to reach a deeper meaning of events, phenomena, or situations. There is an investment from the researcher to not only to understand the experiences of the participants but also to build his or her own meaning, whether it is to agree with or challenge the findings. The focus is always on the participant experience but allows for a change in the researcher's assumptions of the event, or situation (Agee, 2009).

Rationale

Qualitative methodology was most appropriate for this study since the purpose was to discover individual perspectives, understandings, and meanings of the process-oriented approach to leadership. I sought to look for thick descriptions of a phenomenon from a relatively small group of leadership professionals. Therefore, the topic would not

be suited for a quantitative study for three reasons: (a) the study was focused on the discovery of in-depth individual experiences and thus did not lend itself to an objective approach to data collection; (b) the population of CMOs in a specific healthcare system hospital would be insufficient for proper statistical analysis; and (c) my role as researcher relied on personal experience as fundamental to the exploration of the findings.

The constructionist worldview fit well with my project as the guide for my methodology and design. The interest in the topic and context was driven by my experience and background, yet I was malleable in my assumptions toward the findings. Using a constructivist philosophy accounted for my ability to change my personal understanding of my participants throughout the evolution of the project. As I listened to their stories surrounding how they viewed the role of being a unique physician leader, I was intimately engaged in what meaning they made of the issues and situations they faced and transposed these experiences over, and under, what I assumed was happening. Overall, how my participants and I formed a new understanding of the experiences within the defined context of my study was what had to percolate to the top.

Method

The methodology informs the decision to use an explicit design for my dissertation. Creswell (2013) stated that the method, or design, is the strategy employed under the methodology that provides the specifics for the inquiry. Denzin and Lincoln (2011) described the design of a research project as the strategy of inquiry. Overall, the design sets the stage for how the research will be done and, like the choice of

methodology, is driven by the topic, purpose, and research questions. This dissertation study employed a qualitative methodology to explore the lived experiences of CMOs working in a large U.S. healthcare system. This focus lent itself to an in-depth look at the process of leadership as it was performed by a small group of physician leaders within this system. Accordingly, a case study design was the choice for my dissertation and is discussed in the next section.

Case Study Design

The definition of a case study reveals a twofold perspective (Yin, 2013). The first is the desire to explore real-world phenomena bounded within a specific context. In this way, the case study allows for both to be examined for pertinence of what is desired to know. Additionally, Rowley (2002) noted that case studies can examine a phenomenon in a new way when prior theory has been found inadequate. The method, thus, separates itself from other designs by enabling the study of both the specific interest of the researcher and the context concurrently in a way that is open to a new lens (Yin, 2013).

The second perspective considers the components of a case study. Yin (2013) discussed case studies as a focus on the unit of analysis guided by research questions and propositions, which produce criteria-bounded interpretations. Merriam and Tisdell (2015) pointed out that the most important characteristic is the definition of the case as an individual, object, or process within a bounded system. They further explained that if the researcher cannot recognize delimiters, such as a limited number of participants, observations, or data, then the research cannot be considered a case study. In all, these

characteristics support the inclusion of a guiding theoretical framework to bracket the varied types of case studies (Yin, 2013).

Yin (2013) listed case study types as explanatory, exploratory, or descriptive. Stake (2013) listed types as intrinsic, instrumental, or collective. An additional typology includes a single versus a multiple case study (Merriam & Tisdell, 2015). The choice is based on the research purpose and questions. For example, the use of a multiple case study allows for comparisons between similarities found in different cases, and an explanatory case study looks to prove causality beyond experimentation in real-world situations (Baxter & Jack, 2008).

Using a multi-case or single-case design as well as a multi-unit versus single unit of analysis is also a consideration (Yin, 2013). In a multi-case model, several contexts exist with multiple embedded cases (embedded approach), or multiple contexts can encase one case each (holistic approach). In a single-case model, an embedded approach recognizes multiple cases within one context, and the holistic approach finds one case per context. The most important parts to identify are the units of analysis and the contexts that contain them (Merriam & Tisdell, 2015; Yin, 2003, 2013).

There are several rationales for using a multiple versus single case study, and Yin (2013) provided guidance in this regard. Using a single case study may be best with an unusual or previously inaccessible case. A single-case approach focuses on one case in either one context or multiple. The multiple case study may work best with the replication of results under the guise of a theoretical framework. Thus, *theoretical replication* (Yin, 2013, p. 57) could provide a basis for propositions of practice. Overall,

a decision regarding which case study to use requires careful consideration of what data are being sought, especially in regards to defining sampling, as discussed in later sections (Merriam & Tisdell, 2015).

Rationale

The exploratory case study design was appropriate for this study since I was interested in discovering, by using a specific theoretical lens, the experiences of CMOs in their role as unique leaders regardless of being employed by by one of the several hospitals within one healthcare system. Additionally, studying the role of CMOs has no clearly defined relationship between what is experienced (the unit of analysis) and the context (multiple views of the role by each CMO) (Baxter & Jack, 2008). In other words, the context that houses the experience, or the view of the role, is as important as the experience on its own (Yin, 2013). Knowing this, other designs available to qualitative inquiry, such as phenomenology, ethnography, and narrative inquiry, may not have revealed how important the situation, or context, was relative to differences in experiences of each CMO.

My dissertation purpose and questions informed the type of case study (Creswell, 2013). The unit of analysis for my study was the multitude of rich descriptions through theexperiences of each CMO performing their role within a group of hospitals under one healthcare system.. The context of my dissertation is the role they perform and is encased by the discovered themes within and across the experiences of each. This offered multiple views regardless of locationbut with a single context performing the role of CMO.

Sample Selection

The approach to sampling for my project was purposive sampling. This type of sampling is used when the researcher endeavors to explore and understand specific experiences that can only be obtained from certain individuals, observations, and/or documents housed in the case (Merriam & Tisdell, 2015). Robinson (2014) provided a process for purposive sampling in qualitative studies, including a four-point approach specific to case study research: sample definition, sample size, strategy, and source recruitment. Each of these points, which help inform the audience of the sampling pathway for identifying and obtaining the desired sample, is discussed next.

The definition outlines inclusion and exclusion criteria as well as the homogeneity, or heterogeneity, of the participants and documents (Robinson, 2014). The sample size required for qualitative studies is driven by both the practicality of data collection and the availability of the sources. The sampling strategy determines how the sources are related to the research purpose and theory of interest. Source recruitment is the approach used to obtain participants for the study as well as to gain additional participants through recommendations. The following paragraphs describe further the four-point approach to sampling specific to this study.

Sampling Definition

My study included all physician leaders with the title of chief medical officer with in the hospitals of a south western U.S. healthcare system. The position comes with assumed homogeneity, but examination of the job descriptions from two of the hospitals in the system suggested the CMO role may differ from position to position and/or

hospital to hospital. As such, I developed inclusion and exclusion criteria as defined next.

Inclusion criteria. The sample CMO participants' experience in the position ranged from novice CMOs to seasoned veteran CMOs. The study also included CMOs who had left the position but had experience in the position within the last 12 months. In addition to the CMO title, I allowed for prior CMOs who were working in a similar capacity within the healthcare system.

Exclusion criteria. Physician leadership positions within the healthcare system include chief of staff, chief patient experience officer, and chief executive officer. Since my study was interested in the experience of CMOs specific to working within and across two groups, there was neither inclusion nor exclusion for demographic-specific data, of the participants, e.g. age or gender. The demographic data was collected but as information for potential future studies.

The rationale for the inclusion/exclusion criteria in my study involved the specific role of the CMO as a position between the physician and administrator groups. In this role, the CMO is uniquely charged with connecting two distinct, autonomous factions in a hospital and not beholden to a linear, hierarchical leadership structure (Larkin, 2012; Myers, 2013; Runy, 2009). Consequently, viewing the role of the CMO from a nonlinear leader perspective fit with the purpose of my project.

All other physician positions, including those noted above, were excluded since they are commonly involved in linear, hierarchical leadership arrangements, such as leader-member vectors of leadership. Those roles are contrasted with the role of CMOs,

who work laterally between groups without traditional leader-member authority. As a result, including other physician leader-member models would not have been appropriate for this study.

Sample Size

The qualitative approach to this study explored the rich descriptions of CMOs as they experienced their tenuous position within the hospital. Unlike quantitative survey data, which require enough data for statistical inference, I sought to better understand the individual experiences of a small, unique group of physician leaders who perform a specific job. Therefore, I anticipated the size, or number, of participants to be enough for thematic analysis but not enough for statistical inference (Lincoln & Guba, 1985). The total sample size was limited to the CMOs employed by the healthcare systemhospitals.The final sample size was 10 participants and each provided consent per Institutional Review Board approval through Texas A&M University (Appendix A).

Identification Strategy

As noted, I chose a purposive sampling technique to identify the participants and documentation that would best fit the purpose and theoretical framework of the study. This strategy helped ensure that my participants had adequate experience and insight to speak to the research purpose and answer the research questions (Robinson, 2014). The inclusion/exclusion criteria noted above guided the recruitment of participants.

Recruitment of Participants

The identification of participants, as well as the location of and permission to obtain documentation (Appendix B), began with a gatekeeper (Hays & Singh, 2011).

Since I am a medical practitioner and leader in one of the healthcare system hospitals, I identified a gatekeeper without much challenge. The gatekeeper for my study was a recently retired CMO with access to most of the CMOs within the system. This individual's experience was invaluable as both my key informant and the first participant to be interviewed.

Data Collection

Interviews were used to collect the in-depth experiences of the participants. Interviews are a personal, one-on-one dialogical approach that allows for a relationship to develop between the researcher and the participant (Creswell, 2013; Merriam & Tisdell, 2015). I employed a semi-structured interview type. Hays and Singh (2011) defined semi-structured interviews as a *form of interview that uses a protocol as a guide and starting point for the interview experience* (p. 431).

Instrument

The basic tool for gathering the rich experiences from participants in qualitative studies is the human instrument (Creswell, 2013; Merriam, 2002). The researcher is not only the instrument for gathering data but is also a real-time adaptor to the participants' responses. Since the researcher is involved in the process and not an outsider looking in, he or she can adjust and adapt to the respondent in ways not available in positivistic paradigms (Merriam, 2002).

The researcher, as the instrument of data collection, is only human and is wrought with bias and interests that may affect the data-gathering process. In quantitative research, bias is dealt with by using a variety of procedures, whereas

qualitative research invites it as an integral part of collecting and interpreting the data (Merriam, 2009; Merriam & Tisdell, 2015). Ultimately, the qualitative researcher makes subjectivity transparent in the disclosure of how they came to be interested in the topic. The topic of bias is discussed in detail in the analysis section under Role of Researcher.

Interviews

I began the interview process by sending an introductory email to the potential participants. Follow-up emails, phone calls, and/or letters provided back up when no response was obtained within 10 business days. Once a participant agreed to take part in the study, I used Doodle (www.doodle.com), an online scheduling program, to contact the CMO's secretary and secure dates and times. Each participant underwent an intial interview lasting one hour and a follow up interview lasting 30 – 40 minutes. This generated an average of 10 - 15 single-spaced pages of transcription for each interview.

I used Creswell's (2013) process for interviewing. This included:

- Deciding on interview question type—I used semi-structured questions to interview participants.
- Identifying interviewees—I employed purposive sampling to single out participants able to best answer my questions.
- Determining the means of conducting interviews—I conducted the initial interview with participants face-to-face when possible but engaged video interviews via Skype when distance and/or timing was prohibitive. I performed follow-up interviews in person, by telephone using conference call recording, or online using Skype.

- Determining a recording procedure—I used a voice-activated recording device during face-to-face interviews. Skype and www.freeconferencecalling.com offered voice and video recording in a virtual environment. I brought pen and paper for note taking and back up in case of technology failure.
- Establishing the protocol for interviews (Appendix C)—My protocol adopted a list of time, place, persons, position of interviewee, a brief description of the project, and questions. A request was made of the participant for the names of other participants who might inform my topic, and a word of appreciation for participating was provided.
- Determining the location of interviews—When possible, I conducted the interviews in the office of each participant, which allowed for identification of nonverbal cues and observations. When I was unable to interview on location, Skype sufficed for face-to-face and nonverbal interactions.
- Providing a consent form (Appendix A)—I provided an Institutional Review Board (IRB)-approved consent form to each participant after arriving at the interview. For Skype interviews, the consent was emailed to the participant and discussed prior to starting the interview. The consent form provided the information required for interacting with human subjects as outlined by the Texas A&M University IRB.

The process listed above applied to all participants in the study. Additionally, each participant was provided a pseudonym for confidentiality. The following strategy was used with participants.

- Establishing access and contact—As a medical practitioner in a leadership role of one of the hospitals in the study, I had access to potential participants. Although my status afforded an informal gatekeeper relationship, it was important to engage the formal leadership structures established in the hospital prior to starting the interview process. This reflected my desire to follow customary lines of access and availability of potential participants embedded within the organizational structure of each hospital. I reached out to participants on my own initially through email, phone call, or visits to their offices. This allowed me to gauge the strength of our impending relationship.
- Seeing the interview as a relationship—The interview is a relationship between the researcher and the participant. It is a social exchange of ideas and information that is both private and trusted. The exchange consists of phases: a beginning, middle, and end (Seidman, 2013). The introductions to my participants set the stage and ground rules. The rapport in the middle was a back and forth dialogue where information was grown, agreed upon, and challenged. Finally, the end consisted of feedback and final agreements regarding the information created.
- Sharing the results—The thematic descriptions that arose from interviewing participants were thick with discoveries related to my research purpose. The discoveries were not just for my benefit as the researcher but were also for the benefit of the participants. The newly gained knowledge adds to the field of CMO practice and to the lives of the individual CMOs who took part in my study.

Documents

Select documents were included in the collection of data for my project. The documents consisted of my personal journal of the dissertation study journey (Appendix D) and the job description of the CMO position within both healthcare system hospitals (Appendix E), that guide how CMOs interact with the medical and administrative staff. Merriam and Tisdell (2015) discussed the importance of authenticity when including documents as data. Ultimately, it was my responsibility to authenticate, by way of origin and author, and show how these documents were relevant to the context of my project.

I used the noted documents in various ways. I use the job descriptions to aid in the creation of the research questions, compare and contrast the written job functions with the expriences of my particpants, and as a delimiter to better understand the contrasts. The personal journal provided a reflective view of my journey through the research process. By using the journal, I was able to see how my research focus and direction was modified to the meet and contend with discoveries in the analysis.

Data Analysis

The data analysis consisted of analyzing participant interviews and documents from hospitals in the healthcare system. I relied on Creswell's (2013, 2014) suggestions regarding the analysis of my case study data. Creswell (2013) discussed the data analysis spiral, which recognizes the nonlinear process of collecting and analyzing data simultaneously. Subsequently, the analysis became richer with each interview and document review. The following provides the step-wise approach for analysis of the data, the use of a first interview as formative, a brief description of the role of the

researcher, and the establishment of trustworthiness, credibility, and authenticity of the findings.

Step-by-Step Analysis

Creswell (2014) described a practical path for analyzing case study data that works well for my dissertation. It is important to note that the steps listed below do not reflect the parallel process of collecting and analyzing data common in qualitative research. Although the steps are listed sequentially, I was also continuing to collect more data from new participants and performing follow-up interviews during the analysis process. The steps for data analysis were as follows:

- First, I organized the raw interview data and documents into workable and sensible partitions. This was done using NVivo for Mac, a computer-assisted qualitative data analysis software (CAQDAS) package. I used NVivo for Mac due to the ease of inputting and coding several different types of data. I also found this specific CAQDAS to be more user-friendly and aesthetic regarding the display of grouping codes, categories, and cases.
- Second, I performed an initial review of all the data categorically to identify central ideas, similarities, and differences.
    - Initial coding involved dividing words, phrases, and even paragraphs into chunks that made sense so that the meaning could stand on its own (Lincoln & Guba, 1985). Saldaña (2015) viewed the initial coding as an open-ended looking at all the source data. The use of NVivo for Mac

provided the best way to track the collected data and build strategies for comparing data components (Saldaña, 2015).

  - Continual coding included the use of nodes built within the NVivo for Mac software (NVivo uses the term *nodes* to group coded data under a word or term that describes the data within it). Each node embodied a set of codes from the data, which helped develop commonalities within the participant responses. In this way, I modified the constant comparative method by Glaser & Strauss (1967). Their work, which is commonly used in grouded theory, helped guide further reduction of my data by having me continually review, group, and re-group my codes within the nodes as new interview transcripts were integrated. In this way, I recurrently reviewed my data, in the form of both nodes and code, which facilitated the emergence of new categories and eventually themes (Creswell, 2013). This process eventually led to the saturation of my data (Lincoln & Guba, 1985).

- Third, I identified themes that arose from the nodes and categorical data. Creswell (2013) described thematic analysis for case studies as holistic, referring to the entire case, or embedded, referring to a particular component of the case. The examination of data percolated these themes as pertinent to key issues of the case and provided richness to the discovered content.
- Fourth, I continued to review and reflect on my themes as new interviews or follow-up interviews were transcribed. This developed further assertions about

each participant case and provided explanation and meaning regarding each new insight or issue (Creswell, 2013). The continual thematic review provided what had been gained by learning about and performing the study (Lincoln & Guba, 1985).

- The final step collated the findings in a manner that best described the experiences of my participants though the established themes. As part of the trustworthiness of my research, which is discussed in the next chapter, I shared the results with the participants and included challenges to my findings as additional data.

Saturation

Since I analyzed data parallel to data collection, I could claim saturation of data near the end of my listed participants. After several initial and follow-up interviews, the data became redundant, and no new information was discovered, even with the inclusion of new lines of questioning. Once there was no new information relative to the prominent themes, which were fully developed, data collection was discontinued.

First Interview

The participant that was interviewed first helped test the components of the research design (Creswell, 2013; Yin, 2013). For my dissertation study, a recently retired CMO who met the inclusion criteria of the project was identified and assisted in a formative role. Using the first interviewee in this way helped build or adjust the line of questioning, assess my observation skills, fill in potential gaps in the research process, and check assumptions.

Role of Researcher

A qualitative research analysis called for a note regarding the relationship between the researcher and the participant. This included the recognition of myself, the researcher, as the primary instrument used to collect and analyze the data. My researcher/participant relationship reflected an elemental and vital component that defined and helped expose potential biases in the inquirer's role (Merriam & Tisdell, 2015).

Trustworthiness

Validity and reliability of the findings in research are significant components of a research project (Merriam & Tisdell, 2015). The validation of the findings and reliability of the study instrument are based on the methodology. There are differences regarding the terminology regarding believability and rigor of research based on whether the methodology is quantitative or qualitative. Ultimately, though, the findings are valid and reliable when they are found to be generalizable (quantitative) and/or trustworthy (qualitative). For the purpose of this section, I used the terms validity and reliability but the following sub-sections reflect how such terms are used in a qualitative project.

Credibility

For quantitative research, validity is accomplished by identifying internal and external threats toward the results. Internal threats include the experiment design, treatment, and/or participant selection. External threats include inferential and experimental interactions' issues (Creswell, 2014). For qualitative research, validity

means truthfulness, or credibility of the findings (Merriam & Tisdell, 2015). To find the truth, all must agree with the discoveries; the researcher, the participant, and the reader.

Qualitative validity also includes internal and external components. Internal threats primarily involve the subjectivity of the researcher (Merriam, 2009). The biases and assumptions about the research topic and expected responses heavily influence the collection and analysis of the data. External validity is the degree to which the findings are felt to be true beyond the participants (Lincoln, Lynham, & Guba, 2011). In other words, the themes discovered during the analysis of interviews and documents possess enough depth to have meaning for similar people and/or situations (Creswell, 2014).

Several procedures are available to solidify the truth of the findings and similarity of their meaning across other groups or situations. My dissertation study used a list of procedures to support the validity of my qualitative findings. These included (a) rich descriptions, which used the voice of the participant when displaying the findings; (b) adequate engagement using initial and follow-up interviews; (c) member checks using email to confirm the recollection of the interview's accuracy and meaning; and (d) a CMO peer reviewer from another Texas-based healthcare system. This individual was interviewed and presented the thematic findings. The responses from the peer reviewer were used to support, add to, and/or challenge the discovered themes.

Consistency

The reliability of the instrument in quantitative research is based on the strength of the instrument used to collect data and the ability to replicate results (Creswell, 2014). Instruments in quantitative research include any mechanism that can measure data

numerically. The prominent use of surveys in quantitative research allows for responses to be labeled with numbers and subject to statistical inference.

The instrument to collect qualitative data is commonly the researcher him- or herself. The data are collected through interaction and dialogue—usually through one-on-one and/or group interviewing (Seidman, 2013). Since the researcher is performing the interview/interaction, he or she is subject to subjectivity. This includes preconceived notions, assumptions, and/or biases about the participants and/or the situation/phenomenon (Merriam & Tisdell, 2015).

Ensuring credibility of the human instrument is challenging. Unlike quantitative work, there is little objectivity when the researcher seeks to understand his/her participants. For this reason, procedures exist to ensure reliability of the findings when the researcher is the primary tool of data collection. My dissertation study used open-ended interview questions to discover the experiences of my participants. To enhance reliability, I employed a reflective journal (Appendix D).

The use of a reflective journal through the research process is what Ortlipp (2008) called the *researcher's baggage* (p. 698). The reflective journal is a chronological account of the researcher's journey through the research process—all phases of the project. In this way, the researcher offers transparency of his or her aims, goals, assumptions, and belief systems. I used a reflective journal to disclose my struggles, fears, and concerns but also to exhibit my excitement and surprises and to explain changes to questions while working with the participants. I offer the journal as a window to my personal voyage through my research process.

Researcher Bias and Assumptions

In qualitative research, the researcher is intimately involved in all aspects of the project. Since objectivity is difficult when using a human instrument, qualitative studies call for the identification of biases and assumptions held by the researcher (Merriam & Tisdell, 2015). In fact, the views of the researcher are integral because the interest in the topic, or phenomenon, is driven by the desires of the researcher. Because of this, the researcher brings a depth of experience and curiosity that centers the purpose of the project (Merriam, 2009).

The challenge with researcher bias and assumptions in qualitative research primarily concerns expectations (Merriam, 2009). These include the expectations of what will be found when interacting with the participants and how the lines of questioning favor the researcher's beliefs about the situation and/or phenomenon. Thus, the researcher's subjectivity must be made evident to thwart tainting the findings (Maxwell, 2013).

The biases and assumptions for this study are discussed below. As noted in the literature review, I brought a wide range of professional clinical and leadership experience to the project as an insider. As such, my biases and assumptions stemmed from what I had observed in board and committee meetings and conversations I had had in informal settings, such as the doctor's lounge. These are the three primary assumptions and biases that framed my perspective at the onset of my research:

- I assumed that a hospital CMO functions as a connector between physicians and hospital administrators. This would include strictly being a go between for both

sides. As a result, the CMO had to be both supportive and protective of their physician colleagues and the hospital administrators that employ them. To me, this role seemed to be in constant conflict as the separation of each in terms of what was important, were essentially polar.

- I saw their work as very tenuous and wrought with challenges, both socially and professionally. They are no longer purely clinicians, and as the result, appear to contend with negativity and face cynicism from physician colleagues. As such, I assumed that CMOs had to choose what they would be, either clinician or administrator; they could not be both.
- I believed that research was failing to guide the CMO position. This was based more on informal discussions than exploration of current literature. Consequently, I viewed the role as poorly understood and open to high variability in leader practice and leadership strategy.

Positionality and Reflexivity

In qualitative research, the experience, beliefs, and assumptions of the researcher are highly involved in all areas of the study (Merriam & Tisdell, 2015). Although the findings are the voice of the participants, it is the researcher's framework and lens through which the findings are presented. I used a constructionist lens to make meaning of the findings as both my participants and I built meaning and understanding from the responses. Thus, I am intimately involved in making meaning of the responses.

In Chapter II, I presented my own experiences as part of the literature review under the auspices of empirical input. My view of the CMO participants and their place

in the realm of U.S. healthcare motivated the interest to understand them better. What I was seeing, as an unofficial observer of their behavior in board and committee meeting, left me with a sense of confusion regarding what they do. As I came to understand the importance of their position in moving U.S. healthcare forward, I discovered how little they were understood.

In this subsection, I present my experiences as I selected and interviewed the participants, my assumptions about the CMO position, and how we, the CMOs and I, grew through the research process. The rationale for including this part of the findings is found in Merriam and Tisdell's research (2015), which disclosed that having insider access and/or similar background to the participants may offer more openness from the respondents. Additionally, what I brought to the interviews (e.g., assumptions about what I would hear) requires transparency throughout the discussion of the findings. I begin with positionality regarding how this helped to gain access to my participants and how my background helped bring out mutually understood responses.

Positionality

My position in a local hospital system affords me the opportunity to interact with both the medical staff and administrators of the hospital. I first became aware of the CMO role in the hospital in executive committee meetings where I was, and still am, a liaison for my profession and the hospital. In these meetings, I was part of interactions between the representatives of the medical staff and the executive team of the hospital. The executive team, or C-suite, consisted of the CEO, the chief nursing officer, and the CMO.

The CMO, as an employee of the system hospital, is a representative of the overall medical staff, both employed physicians and independent, nonemployed physicians. As a clinician liaison within the boardroom, I was involved in components of the discussions regarding patient care, cost containment, and risk management, each one vital to moving the health system forward. I had numerous opportunities to interact with the CMO during these discussions, which allowed for a sense of credibility when approaching them for this project.

I gained access to my participants in many ways, but one of the most effective ways was sowing the seeds of my project with the CMOs by just walking up to them after a meeting and discussing it with them face-to-face. Although this was not possible for the CMOs in the outlying system hospitals, I was still able to use other forms of contact to either directly contact the CMOs of that system or indirectly contact them through the divisional CMO. I found that introducing myself as a clinician whose profession was closely tied to physicians opened the door by providing instant credibility with potential participants. Overall, I successfully used my status as a clinician liaison and my profession to secure the interviews with my participants.

Reflexivity

During the research process of my dissertation, I kept track of how my project was changing my assumptions about the CMO profession. I was challenged during my data collection and analysis regarding the evolution of my research questions, the shift or disappearance of my theoretical frames, and my understanding of the real-life

experiences of my participants. I found that using a reflective journal, offered in Appendix D, was integral to charting my growth in this project.

Initially, I used the journal to re-visit the research questions for the project and continually align questions to match discoveries during the interview process. In this way, these adjustments to my inquiry helped develop the findings that I was looking for when I envisioned this dissertation. Realistically, I had to make several adjustments to my participant questions that led to changes in my dissertation research questions. As I went through each interview, I made both subtle and sometimes drastic changes to what I planned to ask either the next participant or the same participant but in a follow-up interview.

My growth through the iterative research process of analysis was profound and guided decisions such as what I displayed in my findings and what was left in the data. That is not to say that parts of my data were worthless, but in going from the inductive to the deductive phases of my analysis, prominent and repetitive responses called for more focus. Thus, the findings encompass primarily the voice of my participants in conjunction with the evolution of my experiences during the collection process.

I started the project with a preliminary theory that was felt to be dominant among my participants. This was based on my observation of them and my personal assumptions of what they do. What I found during the data collection and analysis was how little I knew about the CMO position. As I experienced the divergence from my original theoretical frame, I pushed outside of the initial assumptions to see the position

from various theoretical frames instead of one. Overall, I learned to let participants decide, or develop, the framework instead of me.

The process of working with my participants was both insightful and energizing. I now look at CMOs in committees that I am a part of with a much wider lens of understanding. Additionally, by identifying and disclosing my part in this project, I help to maintain the voices of my participants as to the reality of their jobs and give credence to the findings.

Chapter Summary

Chapter III revealed the heart of my research process. The purpose of my study and research questions anchored the rationale for my methodology. The desire to fully understand the experiences of my participants as unique physician leaders called for a constructed meaning between myself as researcher and the study participants. To accomplish this goal, I engaged a qualitative method focused on a specific healthcare system with a substantive group of participants in a case study format.

My constructionist worldview underscored the research design. This lens directed the steps taken to identify participants as well as collect and analyze the data. Each step was undertaken for a rich and robust display of my findings. My interests, shared strongly by the participants, provided the depth needed to adhere to the stages of the design. Hence, each phase of the design built upon the next in a synergistic fashion.

A discussion regarding trustworthiness in qualitative research was offered in this chapter. The section on validity and reliability highlighted procedures used to establish credibility and authenticity of the data. The final section, regarding my subjectivity as a

researcher with inherent experiences, assumptions, and biases, was presented candidly and elemental in establishing transparency and trust. Overall, this chapter displayed, explained, and rationalized my research design. The next chapter presents the study findings

CHAPTER IV

FINDINGS

Introduction

The differences between physicians and administrators are glaring. Long, Cunningham, and Braithwaite (2013) stated, *the health care sector is a context that is rich in isolated clusters, such as silos and professional tribes, in need of connectivity* (p. 158). Further, *each has its own language, values, culture, thought patterns, and rules of the game* (Kaissi, 2005, p. 165). The work of CMOs dealing with tribes resides at the crux of my work. The issues associated with being in such a tenuous position bring out different, yet similar, responses across all the participants in this project.

The findings offered in this chapter arise from the detailed analyses of initial and follow-up participant interview transcripts using various media, documents, and peer-reviewed literature. The names provided in the individual responses are pseudonyms as their identities are protected per the IRB protocol. A stakeholder reviewer (also given a pseudonym) examined the preliminary findings, which provided additional data and support, thereby adding more depth to the findings. The culmination of all this data resulted in a robust understanding and rich descriptions of the experiences of my participants.

The purpose of this study, which used a qualitative methodology and design, was to explore the experiences of chief medical officers employed by hospitals within a south central U.S. healthcare systemin their emerging role as physician leaders working with

both the physician staff and hospital administrators. It was also the purpose of this study to discover and better understand issues faced by CMOs that affect their performance in this unique role. The research questions were as follows:

- What are the experiences of CMOs as healthcare system hospital employees?
    - How do they define the role?
    - How do they succeed in the role?
    - How do they learn to perform the role?

What are the primary issues faced by CMOs and how do these issues affect their ability to perform the CMO job?

This chapter is subsequently organized into the following sections. The first section offers vignettes of my participants in order to inform the reader of the background and personality of each. This is followed by the dominant themes that arose from the analysis of the data. Each theme is displayed using the voice of the participants and followed by a discussion that includes the researcher's reflections and any relevant literature discovered during the analysis in support of the theme. The second section displays the relationships between the themes and demonstrates how these connections help one to better understand the complexity of the CMO position. The third section focuses on the connection between the themes and CMO performance. This section reveals a set of fundamental behaviors gleaned from the participants that move the hospital and healthcare system toward high-quality and affordable patient care within a patient-centered business model. The fourth section presents a list of pearls of wisdom culminated from the vast insights of the participants to help future and new CMOs. The

final section offers my positionality and reflexivity while working with the participants, which includes my status as a clinician and leader as well as my interests, experiences, and beliefs relative to the interacting with my participants.

Participant Vignettes

The participants were all medical doctors (MDs) and come from multiple areas of medicine. All except one of the CMOs were male. All the CMOs had experience in their specialty for some time prior to entering the CMO position. Although each of the participants was intelligent and knowledgeable, there were differences in personality and temperament. The following vignettes of each participant are intended to give the reader a sense of their personalities and background in order to understand the responses more completely. The descriptions were accurate as of the time of this study.

Dr. Provasi is a very nonemotional white male in his 60s. He has a military-like personality and is introverted. He is a retired CMO from one of the healthcare system hospitals, and his medical specialty is internal medicine, but he has been working as an inpatient hospitalist for some time. His business attitude provides a sense that the administrative side of medicine is very straightforward, and physicians ought to come around to understanding and becoming invested in the business of medicine. Due to his cut-and-dried style in the position and his dedication to the care of patients, there are times when he butts heads with administration. Overall, he is well respected by his physician colleagues as a practicing physician.

Dr. Davis is a very talkative white male in his 40s. He is extroverted yet very thoughtful. He continues to practice as a physician and currently holds an executive

position in the healthcare system. His short tenure as CMO was very challenging, yet he met these challenges with vigor and concentrated on the care and safety for the system's patients. He is well respected by his colleagues for continuing to maintain his clinical practice but felt that his life was too busy to do both. Thus, he felt that his time as CMO was reactionary and not very productive.

Dr. Sprecher is a very talkative and gregarious white male in his 50s. He is clearly extroverted and very knowledgeable about analytics in medicine. He is a practicing OB/GYN physician. His tenure as CMO was primarily as the leader of physician engagement and integration. This entailed gathering practice data and assimilating variable medical and hospital business practices. Although he only spent a year in the position, he continues to be utilized by both his physician colleagues and administrators to develop practice strategies. He is well respected by the medical staff since he has been in the community for many years.

Dr. Ruda is a soft-spoken and deliberate white male in his 50s. He was very interested in the project although he is very new to the CMO position. He is a family practice physician who less than a year ago left his established practice to take the CMO position. He has an extensive history as a leader among his peers but not in a full-time capacity. He is just beginning to experience the reality of being both an administrator full time and a clinician part time. He continues to practice medicine in the evenings and weekends to maintain his craft and the respect of his colleagues. Since he is a new CMO, he still has a lot more questions than answers regarding the day-to-day work of the position.

Dr. Zwicke, the only female CMO interviewed working for one of the system hospitals. She is petite and very soft-spoke and thoughtful. There is an air of humility about her although she was strongly solicited to become the CMO by her physician peers. She is a surgeon by trade and continues to practice on a part-time basis in a nonsurgical capacity. When discussing the challenges of working with her colleagues toward changes in practice behavior, she seems hesitant and nonconfrontational. She claims that the newness of the position has brought much self-reflection and a desire to get more proficient. I sensed that she is not entirely comfortable with the role as both a clinician and administrator.

Dr. Wolfe is a very outspoken and honest white male in his 50s. I was instantly attracted to his openness when discussing the CMO position. He was emotional and even crass at times when reflecting on his role as both a clinician and administrator. He is a surgeon by trade and continues to enjoy seeing patients. He states the CMO position takes more and more of his time, though. He was very honest about his frustration with defining the job and felt lost when trying to describe his performance in the position. He was very quick, like all the CMOs I interviewed, to put the needs and safety of the patient first. He is well respected by his peers for his honesty and empathy.

Dr. Esser, the only non-White physician interviewed, is in his 40s. He is very forthright and knowledgeable about the position. He is a hospitalist by trade and has held numerous leadership positions in his young career. He seemed very comfortable with leading and for the most part had very positive experiences with both his peers and hospital administrators. He was also very responsive to follow-up inquires during the

data collection phase of the project. He continues to practice medicine but in a limited capacity and feels that this provides additional credence to the CMO position.

Dr. Joseph is a retired medical specialist. He is the oldest individual that I interviewed. He is a very quiet and thoughtful individual who offered a vast number of anecdotes across his leadership career. His leadership experience covers multiple capacities, from VP of the medical staff to CMO to a physician advisor. His current job description parallels that of my participants, and his familiarity with the purpose of my project was invaluable. Since he is very well known in the community and among his peers, the fact that he is retired from medical practice has little to no effect on his credibility.

Dr. Endler has a long history as a CMO. He is a white male in his 60s with a vast amount of experience in leadership. He is very straightforward and honest about the position. He is a family practitioner by trade but is no longer practicing medicine. He states that the position as division CMO is more than a full-time job, and he has no time to practice medicine. He does not find this to be a hindrance to credibility of the position but does not work with hospital medical staff as much as he works with the regional executive group. I was grateful to get time to interview him because he is very busy and had to reschedule the interview on more than a few occasions. I found his view that the practice and business of medicine are not separate to be refreshing although not as recognized by his CMO colleagues.

Dr. Breimann is the only CMO that I interviewed who is not part of the healthcare system studied. He is a white male in his 60s, who works in a competitor

healthcare system. He is a surgeon by trade and continues to practice part time. He was very animated, honest, and forthcoming about the challenges and solutions regarding the CMO position. He was very proud to be part of what he felt to be a very doctor-friendly healthcare system. He has been a CMO for over 4 years but his credibility comes from his longevity in the community. He reviewed my project, specifically the thematic analysis, providing excellent insight and support for the findings.

Themes

The use of a constant comparison model of analysis creates a richness of participant experiences as the codes drawn from the participant responses are continually reviewed for deeper understandings (Glaser & Strauss, 1967). This method hermeneutically thickens the meaning of the responses as the data are constantly grouped, reviewed, and re-grouped, and prominent phrases, or meanings, surface. Such meanings are then deduced to be true against prior coding and new data. The result is a phrase that encapsulates greatest impact, or meaning, for the project participants and the researcher. For this study, the prominent themes that surfaced were (a) role ambiguity, (b) role credibility, and (c) role development. Each theme is presented and discussed below.

Role Ambiguity

> *As far as our job goes, I still think it is nebulous to some extent. I would love it defined a little bit better (Dr. Wolfe).*

One of the most dominant themes was role ambiguity. All the participants had at least one opinion, but more commonly several, regarding the definition of their role, not

only as part of the system but as a CMO in general. The simple statement above by Dr. Wolfe speaks volumes regarding the lack of a grounded role definition and saliently encapsulates the frustrations expressed by the participants. Accordingly, the CMOs in my study either self-defined the role in general terms or based the definition on what they thoughtt the administration/system expected them to do.

At the same time, though, they were protective of their colleagues and patients, which was reflected in their patient-centered responses. That said, many felt their place was between physician colleagues and administrative employers as advocates with the ability to speak to both sides. The following sub-categories were nestled within this theme and provided further substance regarding my exploration concerning why the physicians in my study took the CMO position, what they experienced as the realities of the job, and what conflicts arose from being both a physician and an administrator.

Taking the job. As noted, CMOs see themselves as physicians first and administrators second. Knowing this, I was curious as to why my participants would take a job that would drastically affect their interaction with patients. What I found was that their concern for patients in terms of care and safety within the system trumped their need to continue practicing medicine on a full-time basis.

> *I think, ultimately, the part that was most interesting was the quality and safety component. I just felt like we [the hospital] did not have a very good grasp of what our quality and safety issues were. We did not have a process in place. That was my first task (Dr. Esser).*

The concern for patient safety affected the decision of all CMOs to take the job. Each had the upmost interest in protecting patients from administrative decisions, which are more business centered. Thus, my participant felt the strongest desire to be an advocate for the patient within the hospital system.

> *One thing that bothers me more than anything, especially patients who are taken advantage of by physicians for the physician's benefit and not for the patient's benefit. That is one of the main reasons why I thought I could make an impact, not only for myself doing the right thing for patients, but maybe having a little bit of an oversight authority of that as well (Dr. Wolfe).*

There were other reasons for taking the CMO position. Some participants wanted the job to affect the larger patient population.

> *As one person, you are limited in the number of lives you can touch there. When you are an administrator and a director of a service line or director of . . . , you set policies, you set procedures, you hire the staff, you train them on how you want things done, and now the impact you are having is on more people (Dr. Davis).*

Other participants saw the importance of advocacy for their profession as translators of clinical language to non-clinicians.

> *I think the CMO, a really effective overall CMO, has to be very engaged administratively. He has to be able to communicate to the nonclinicians in administration what those drivers of physicians are, what is important to doctors, what they see, what he is hearing (Dr. Sprecher).*

Others took a more personal approach to affecting change in a facility where they spent time and grew their medical practice.

> *I was born here, I grew up here, my family is all here, and I have always been very interested in improving our medical facilities locally because it is a very personal thing (Dr. Zwicke).*
>
> *I was . . . clinical . . . for 23–24 years and had been here . . . for . . . years. Our hospital was sold. We had never had a CMO . . . or anything. (Dr. Wolfe).*

Essentially, the reasons for taking the job are multifaceted but were strong enough to make these successful clinicians drastically change their work life. The next sub-category concerns the realities of the job. I found that my participants entered the job with a vision of what it would be like and how they would perform. Many of them experienced unanticipated challenges.

Realities of the job. I found the most glaring reality of the job experienced by the participants was their experiences working between their physician colleagues and the administrators of the hospital. They understand that the position straddles both worlds, and it is important to recognize the realities of trying to help two very different groups work together.

> *You are kind of stuck between two factions that do not always agree. The docs need more of this; they need more of that; they want this done, and their primary goal is to take care of patients in the right way and make their lives easier. The administration's job is to make sure patients are taken care of and make sure*

that financially the hospital is performing well. As such, the CMO has to be the guy in between that sort of has to play the fence a little bit (Dr. Davis).

The CMO position, though, is different from a typical administrative position.

Usually in administration, people are trying to elevate their position; I will just say it that way. You know, a physician is a physician. It is not like, "I want to be chief of staff." No one is aspiring to that, usually. Physician is a role you are in (Dr. Ruda).

Nevertheless, the participants felt it was on them to facilitate a stronger relationship and help both worlds communicate.

To be in that position in between there where I am having to balance people who are at odds with what they think needs to happen, it requires you to cater to both sides, so to speak, and make everybody understand that there is a common ground and that we cannot have all we want on both sides (Dr. Provasi).

The findings support the concept of a common ground and this was expressed by several of the participants. However, the reality of getting to the point of alignment where both groups are working in tandem is a challenge. It requires CMOs to be diligent in their role as facilitators and translators of a common vision.

There is always common ground, though. I found that out, that if I cannot get them exactly what they want, maybe I can get them to at least, what I call, a happy place where they feel that they are somewhat validated in where they want to go and what they want to do (Dr. Provasi).

Another reality of the position experienced by my participants was how they were viewed by their physician colleagues. Each participant had an experience, or two, where they were confronted with the fact that they "went over to the dark side," "sold out," and had become a "suit."

> *I had a few minor confrontations about "Whose side are you on?" and this sort of thing (Dr. Joseph).*

They also experienced significant, and sometimes drastic, changes in relationships with their colleagues that were not usually positive.

> *I have been in the medical community for 13 years, and before I took the job, these were my colleagues and my friends (Dr. Provasi).*

Many of my participants took these attitudes and/or comments in stride, knowing it was part of the job. Most felt that it did affect their understanding of the challenges associated with the role.

> *I knew it was going to happen, was that my relationship with many of my colleagues, and my friends for that matter, were going to change 180 degrees. I was going to immediately be looked at as the enemy. I understood that, and I accepted it (Dr. Wolfe).*

Ultimately, my participants learned to work though these projected attitudes to reach the goals noted above: quality patient care and patient safety.

Conflicting roles. As noted in the prior sub-category, there are challenges with being both a physician and an administrator. The realities of the job call for the CMO to be both an administrator and a physician. The ability to be both is quite unique to the

CMO, and the experiences associated with this category revolve around not only how they view the conflicting jobs but around how they contend with being in both at the same time.

Since the CMO is an employee of the hospital, his or her primary job directives are assumed to be oriented toward the administrative side. The participants understood "who signs the paycheck" but believed that their purpose for being given the role was to facilitate hospital policy while also protecting the patients and medical staff from administrative decisions that could be, or are, detrimental to the patient-centered goal.

> *Much of the definition of the CMO is given by the other administrators. For example, many CMOs are in their position to help with quality of care and safety. Because of their training, however, the other administrators rely on them to push out difficult messages to the medical staff. They are also drawn into strategic discussions, though not what they originally signed up for (Dr. Esser).*

Thus, participants saw the administrative side of their role as being to create and/or foster policies that protect patients, build shared goals, and create camaraderie between the business and practice of medicine.

> *Overall, it's about patient safety from a hospital process aspect as well as observing physicians' clinical practice and being able to stand up for what's right and having a very good working relationships with the chief of staff. Patient experience is #2. And physician satisfaction with the hospital is #3 and very important as well (Dr. Wolfe).*

Reflection. The role development theme that surfaced during the analysis does not exist in a vacuum. Role ambiguity and conflict have theoretical frameworks that were discovered as part of the analysis process. To grasp a more complete understanding of this theme, I briefly discuss assumptions associated with both role ambiguity and role conflict theories described by Katz and Kahn (1970). I also offer my own positionality as described by Davis (2014) for disclosing my own interests and beliefs relative to the findings. Finally, I begin to develop the relationships that arose between the remaining themes as they relate to how the CMOs in my study come to understand who they are, what they do, and how they make sense of their success in the position.

Role ambiguity theory. Role ambiguity is the "uncertainty about what a person responsible for a specific activity should do" (Nuñez Palomino & Frezatti, 2016, p. 167). Several authors, including Katz and Kahn (1978) and Fisher (2001), provided theoretical assumptions centered on not having a clear definition of responsibilities and expectation for a position. Additionally, ambiguity results from a lack of resources to perform the role appropriately. This leads to confusion regarding role expectations followed by frustration and decreased motivation to perform the job well (Fisher, 2001). Principally, clearly defining and supporting what is expected within a role, or job, is central to an individual's motivation to perform that job.

As reflected in my findings, the participants felt the frustration of not having a clearly defined role, even though the healthcare system hospital provides a job description. Interestingly, and likely causing some confusion, the title of the official job description for this leadership role is different from one facility to the next. For example,

one of the system hospitals uses a job description that clearly states chief medical officer, but the formal job description for the CMO of another hospital in the same system states VP of Medical Operations. Even though the list of job activities and directives is almost identical, one must assume that confusion with something as important as the title can lead to perplexity by those who overall are identified as CMOs.

Role conflict theory. Katz and Kahn (1978) stated that role conflict is defined by one or more role responsibilities, each with their own performance benchmarks, which clash or oppose each other. The competing responsibilities force the employee or executives to make a choice of one over the other(s). The instance of role conflict is generally found in performance evaluation and can cause undue stress via the impossibility of performing equally in the opposing, or clashing, roles (King & King, 1990).

The participants in my study confronted role conflict daily. For example, one of my participants had to always balance the needs of the system and the needs of the medical staff. He was confronted by the limitations found in budgets and resources as well as the expensive advancements in patient care technology. For him, this was like being pulled in opposite directions.

> *Then, you have guys who want more money for call, so that is a budgetary item. How do you stay neutral? You are cutting these doctors because they are a contract group, but then you have employed docs who want to make two thousand dollars a night to be on-call. How do you balance that(Dr. Davis)?*

As noted in this and other responses, the clash between the business of medicine and practice of medicine places the participants squarely in the middle of constant cultural battles. Since they see themselves as physicians before administrators, there is the extra layer of divergent goals to contend with. The resolution for the participants coping with role conflict was exemplified in Dr. Wolfe's statement: *Patients deserve good care. That is ultimately the bottom line*. In other words, keep the patient first in the decision-making process and build the role around that goal.

Overall, the participants in this study continued to work through both the ambiguity of the position and the conflicting responsibilities. What is impressive is how they can work through the challenge of performing essentially two roles in one—by recognizing the most important thread woven throughout the hospital and healthcare system, which is, of course, the patient. The CMO participants, thus, keep the focus on the patient, not only for themselves as healers but for their colleagues and administrative counterparts as participants in that goal.

> *All these years I have been a physician, but like I said, sometimes it is a little hard to juggle. I see the value as well in the administrative role because I always try to keep in my mind that my administrated mission is to improve safety and quality of patient care, so I stay focused on that (Dr. Zwicke).*

Moreover, as noted by Dr. Provasi:

> *You have to understand both sides there, so it is like, as I mentioned, walking a tight rope and balancing both viewpoints (Dr. Provasi).*

The next theme concerns how participants experience credibility among their physician colleagues by way of continuing to identify with being a clinician and leveraging social power to address resistance and advocate for patients and the hospitals' medical staff.

Role Credibility

One of the themes that surfaced early in my discussion with CMOs was credibility. This was defined by the participants as a feeling of respect from physician colleagues that allowed the CMOs to help move the medical staff through changes experienced by the healthcare system. Maintaining credibility among their peers helped prevent hospital and system administrators, with no clinical expertise, from making patient care decisions without medical staff support.

> *I would say that most CMOs understand that their organization has to be successful financially, but they want to be viewed as physicians. They wake up in the morning, and when they shave they see a physician. They do not see an administrator. That is why they were hired (Dr. Breimann).*

Patient-centered policies and care directives, per my participants, take place with the respect and confidence from the medical staff because this is the essence of clinical credibility. Those CMOs that do not maintain some type of clinical practice are thus relegated to being labeled "suits" due to the current segregation, at least culturally, between physician and administrators.

> *I think if you say I am just a hospital administrator, I am not going to look out for the docs in any way, and I am not really going to be thought of as a doc, then you*

are going to lose credibility, and the docs are not going to have that relationship with you that you need to have (Dr. Davis).

One challenge, though, for my participants is maintaining a clinical practice in the face of growing administrative demands. As stated, my participants are seen as credible when they maintain some semblance of being a physician. But being both a doctor and administrator is more than a full-time job, and most accomplish this by splitting their time. Although taxing on time and energy, most of my participants understood that clinical practice would be part of the job in order to maintain their skills and the respect of their peers. Only two of my participants have transitioned completely out of clinical medicine: Dr. Elder and Dr. Joseph. The remaining CMOs maintain a semblance of practicing medicine in order to practice what they love and continue to engender respect from their colleagues as group leaders.

Many CMOs do not work as physicians any more. They are not taken seriously as they have no idea about the intricacies of EMRs or being on call. I feel that's why many feel the need to continue some portion of their practice (Dr. Esser).

The sub-categories under this theme include a more in-depth look at the challenges of maintaining clinical practice, using influence as a form of social power to move patient care and business policies forward, and confronting (and at time supporting) resistance within the medical staff of the hospital.

Maintaining clinical practice. As noted above, my findings suggest maintaining a clinical practice, or a clinical presence, is vital to the credibility of CMOs among their medical staff peers. Although a few of them have given up practicing medicine, the rest

were adamant that continuing to use their skills gave them both a feeling of still being a doctor and the social and politic leverage to affect medical staff behavior. The continuance of a medical practice alongside administrative demands creates challenges to work/life balance.

> *I think clinicians feel like someone that is in the administrative side will lose the clinical perspective, and I can see how that could happen because I am in meetings all day long. I am only clinical now because I am choosing to do so after hours. So, I want to do a half day a week in my clinic, they [administration] said no. So, I am doing call one week a month, but I have to go outside of my 9 to 5 (Dr. Ruda).*

As Dr. Ruda indicated, there is only so much time in a day. As the administrative demands increase, clinical practice must decrease.

> *I still have my 30 hours a week of office practice … but the tradeoff was I sold my practice and joined another group so that I just have clinic hours. I do not have all the administrative burden of running the clinic. I do not have to do the insurance, the payroll, all of that credentialing with insurance companies that I did before. So, all at that time, I was doing all of that stuff (Dr. Zwicke).*

A few of the participants were at a stage in their medical career, like Dr. Zwicke, who is an ophthalmologist, where a change in practice was on the horizon, and the administrative position was the next evolution. Others, like Dr. Ruda, who is new to being a CMO, are finding that to *keep a foot in the clinical world*, they must *make time*

to practice medicine among the administrative duties. As time in the CMO position progresses, it is likely that clinical practice will further diminish.

> *To me, that is the real hard part of this whole chief medical officer/physician administration world is that I really think on the one hand, to get to a certain level and to do what you need to do, you probably have to quit practicing clinically. The first side of it is, I think, to really move it forward and to be what is best, to keep a foot in the world of clinical practice (Dr. Sprecher).*

The transition to being more of an administrator also affects the degree to which CMOs can foster changes in their peers' clinical behavior or help the medical staff through the evolutions within the U.S. healthcare system. The power to drive change is primarily influential and discussed next.

Influence as social power. Another challenge for the participants was authority. In an organizational sense, leader authority is what Burke (2012) called "right to" (p. 254). For example, the authority to make the medical staff align with practice protocols or transition to a paperless charting system is met with cynicism and resistance. The CMOs in my study have no real power to make their physician colleagues change. Instead, this study's findings support an influential power.

> *It is a very soft type of power and authority. It is not a direct veto-power or something like that. One way was to work with influential physicians, to have them express the same desires that I had for going forward (Dr. Sprecher).*

> *There is really no way to say, "You have to do this." It is just trying to speak to each one of those physicians that is in opposition to it to convince them of the importance of doing it (Dr. Zwicke).*

The use of influence is prevalent and essential to performing the CMO role. My participants found that to get buy-in from their colleagues, they had to possess the credibility, as noted above, and enter a conversation with facts.

> *[Influencing colleagues] Much more soft. Much more easygoing. Not so pushy. Present some facts and data to them, and then let them make decisions. You can tell when they are starting to come around because they start asking questions. Once they start asking questions, then you know they are ready to change the corner, or turn the corner I should say, about a specific issue (Dr. Wolfe).*

The participants also found that forcing new policies, procedures, and/or protocols was not the best way to get their physician peers on board. To do this, many of my participants take the softer approach noted by Dr. Wolfe.

> *You cannot just go in and say, "This is how it has to be done" and try to convince them. You have to see their side of things too (Dr. Davis).*

In addition, the CMO participants incorporated the importance of system, or hospital, bottom line, and success as pathways to better patient care. Using the patient as the center of the communication between the CMO and his or her colleagues drastically changed the dynamics of any potentially difficult discussion.

For the physicians here, their main concern is taking care of their patients. The administration also wants the patients to be taken care of, so that is kind of the common ground there (Dr. Zwicke).

Although accomplishing buy-in from physicians is essential toward what CMOs do, there are times when they must confront resistance from the medical staff. My findings reflect that dealing with resistance is a part of the job. The next component of the role credibility section presents the participants' views on resistance from the medical staff.

Working with resistance. The final issue regarding role credibility concerns resistance by the medical staff of a hospital and how this is viewed and dealt with by my participants. Working with resistance, in this study, consists of two aims: (a) helping the medical staff transition through the broader changes of U.S. healthcare policy, but more specifically, through the organizational changes of the hospital system; and (b) supporting resistance from the medical staff regarding adverse patient care and safety decisions from administration and advocating for the preservation of physicians as healers.

The first aim, fostering physician through healthcare changes, proved to be one of the biggest challenges for my participants. Several noted the importance of bringing the "old way" into a new era of medical care. Primarily, the CMOs could not just demand change from their physicians because physicians are not traditional employees; in certain circumstances, they are not employees at all of the hospital system.

Historically, clinicians have felt the independence where they do not have a boss, per se. So, it is different dynamic (Dr. Ruda).

The approach toward resolution and success in fostering change must take a different tactic because physicians in the United States are already being burdened with extraneous work beyond direct patient contact.

You cannot just go in and say, "This is how it has to be done" and try to convince them. You have to see their side of things too. "Okay, I get it. If we do it this way you are going to lose a lot of money" or "If we do it this way it is going to totally screw up whatever" (Dr. Davis).

How many new things are we pushing on them, you know? "Oh, you have to use the computer." They are pissed about that (Dr. Wolfe).

The CMOs in my study understand the difficulties experienced by their physicians and find ways to help them. I found that being physicians themselves helped the CMOs explain changes in practical terms.

Being able to see what their [physicians'] concern is about a potential change, and then being able to really get down to what the resistance and find a way to show them. So, some of that is reframing for them. Some of that is being willing to be reframed or informed as to what is really driving them (Dr. Davis).

I think the challenge is then when physicians are involved at the strategic planning level, is to then take what is happening on a tactical day-by-day basis and communicate back to the physicians why you are doing that and how that helps on the strategic level (Dr. Sprecher).

I also found that there are reasons for resistance, which the participants revealed. Mostly, it stemmed from how the medical staff perceived being treated by administration. This was verbalized by the CMOs as administration lip service regarding staff concerns or ambivalence toward clinicians.

> *There are some administrators that see doctors as commodities: "It's a doctor. Just fire that one, and we will get a new one" (Dr. Davis).*

Additionally, the medical staff (physicians) are ambivalent toward administrators and their views of medicine as a business.

> *It is interesting, you know, the nonclinical folks in leadership roles, CFOs, and CEOs, we do not ask them to get a clinical degree, a nursing degree, a PA, MD, but they do kind of expect us to understand the business there, and maybe even get an MBA (Dr. Provasi).*

The second aim of resistance confronting the CMOs in my study was counterbalance resistance. This was described as *not always bad* since resisting poorly thought-out changes, or novelties, that were not good for patient care and safety was important to protecting the core goal of the system, namely, putting the patient first.

> *I was kind of a sounding board to be able to reflect on, and I could advocate. "Hey, look. I know you are asking them [physicians] to do this, but it is not really realistic" (Dr. Davis).*

Supporting appropriate resistance from the medical staff against administrative decisions was a perceived function of my participants.

> *We [CMOs] have a unique opportunity to go, "Whoa, wait a minute. I know that patient cannot pay, but if we do not take care of her cancer, she is going to die. We are going to take care of that cancer." I find job satisfaction out of being a physician that is advocating for physicians and other providers that are trying to take care of patients (Dr. Breimann).*

Moreover, by proxy, advocating for physicians as being healers first meant that the CMO had to advocate for patients.

> *I think that most chief medical officers would say to you, "I want to be recognized as an advocate for our physicians," which is a proxy for saying "an advocate for our patients," not an advocate for enhancing the profitability of our hospital (Dr. Breimann).*

Reflection. The role credibility theme exposes the importance of CMOs as physicians who are still part of the fold, meaning the physician culture. The reasons for continuing to be part of the physician in-group included being trusted as an advocate for their colleagues and patients. To establish credibility among their peers, my participants had to maintain a semblance of medical practice.

The fact that the CMOs continued to practice their art made it easier for them to influence the medical staff of their hospitals. In the findings, influence was power, or authority, although not in a traditional, authoritative way. Instead, my participants used influence, leveraged by their anchor to continued medical practice, to move the medical staff through appropriate healthcare policy and protect the medical staff from novel or poorly thought-out healthcare system practices.

As the findings evolved during my analysis, I reached out to literature and online sources for discussion on the prior theme. My search revealed theoretical assumptions that support the experiences of my participants relative to credibility. Hence, in this discussion, I focus on more recent theories that I could readily relate to the experiences of my participants on a practical and individual level. The first theory is leadership-as-practice by Raelin (2016). The second is intergroup leadership theory by Pittinsky (2010) and Pittinsky and Simon (2007). Finally, I discuss thoughts on resistance found in Burke (2012) and Swanson and Holton (2009).

Leadership-as-practice. The term leadership-as-practice (LAP), as discussed by Raelin (2016), embodies the premise that leadership is an occurrence, action, and/or conversation that is beyond the confines of one person. Instead, LAP de-centralizes the role of a leader toward relationships that allow leading to emerge. The work of CMOs, under the guise of LAP, finds that the work of one individual leader, for example, the CEO of the health system, cannot fully occur without the distinct help of the medical staff of the same system. The CMO, then, becomes the translator, mediator, and facilitator of the healthcare system directives, policies, and strategic planning yet remains considerate of the individual physicians within the system.

> *Moving forward, leadership will be less an individual and more organizational. I think we see things now with the capacity of the Internet and mass communication that group structure gets to better decision-making than individual decision-making (Dr. Ruda).*

The experiences of my participants reflect a de-centralization of leadership. Since CMOs are not bestowed authoritative power to force change, my participants seek to gather consensus between both their physician colleagues and administrators. Using LAP as a scaffold, the experiences of the participant CMOs fit with acting through influence to affect the challenges found between the two cultures.

> *It is almost like we all have pieces to the puzzle, and not everybody has all the pieces. So, it is good to have everybody put their pieces down on that table, and as a group we shift those pieces together to put the puzzle together, versus one person trying to do it on their own (Dr. Ruda).*

To facilitate change, though, the participant CMOs had to practice leadership by taking all voices into account. Raelin (2016) outlined the process, stating:

> The dialogic process is straightforward. It contains three principal ingredients: that the parties display an interest in (1) listening to one another, (2) reflecting upon perspectives different from their own, and (3) entertaining the prospect of being changed by what they learn. It is the last point about being changed that most relates to leadership practice. (p. 127)

Accordingly, the participant CMOs practice listening, understanding, rephrasing, and influencing rather than demanding or forcing their colleagues through the change process.

> *If you are speaking, you are not listening, right? So, ask questions and let people speak their phrase. Try to rephrase what a person is saying so the whole group*

understands what that person is saying, and you yourself understand what that person is saying (Dr. Ruda).

Although LAP is a relatively new understanding of leadership practice, its principles align with the experiences of my participants of facilitating rather than directing changes with their hospital's medical staff. Since relationships are also central to LAP, my participants found that talking credibly and factually persuaded their colleagues toward changes in behaviors that would not have normally occurred. Overall, the use of LAP as a backdrop offers practical explanations of what was experienced by my participants, primarily their success with facilitating change though relationships and credibility among their peers. The next theory offers additional understandings regarding how my participants work between their physician colleagues and the hospital administrators.

Intergroup leadership. The term *intergroup leadership* considers the thoughts and behaviors of leaders who seek to recognize and act upon tensions that exist between distinct groups and integrate them in a positive way (Pittinsky, 2009). The main premise of intergroup leadership (IGL) involves bringing together two or more factions, cultures, or groups for collaboration. Moreover, the general proposition states that intergroup leadership effectiveness in terms of stimulating the quality of intergroup collaborative performance revolves around leaders' ability to engender a sense of intergroup relational identity (i.e., self-definition in terms of one's group membership that incorporates the group's relationship with another group as part of the group's identity; Hogg, van Knippenberg, & Rast, 2012).

The work by Heifetz (1999) operating across boundaries discusses a challenge felt heavily by my participants: the constituency problem. This problem highlights the derogatory view held by constituents of leaders who were once part of a particular group but now work with the other side. The intergroup leader, now labeled a *traitor*, must begin the work of helping his or her constituents to see forthcoming changes that will disrupt the current culture and help them through a loss of their former behavior. To do this, Heifetz suggested reframing the issues to support a shared goal or interdependent behavior.

Reframing is the work of the nonprototypical leader (Platow, Reicher, & Haslam, 2009), who is both a protector of the culture he or she came from, supportive of how his or her colleagues are struggling, and provides the pathway for change to occur with dignity. The key words that come forward in my project to help engrain the intergroup leader mentality are *mediator, negotiator,* and *translator*:

> *I mediate between them and our medical legal representatives (Dr. Provasi);*
>
> *Yeah, that absolutely is part of the job, negotiating ways like "Here is the problem that the docs have. Here are the things that concern them" (Dr. Davis);*
>
> *I think part of it [the CMO role] is you are translating from the physicians to the administrative folks (Dr. Esser).*

All the terms fit with the model of intergroup leadership although there are challenges, as noted, to being in the middle of two disparate groups.

Resistance. The literature regarding organizational change resistance is quite abundant and broad in scope. For the purposes of my findings, resistance was

experienced by my participants in two ways. The first is *ideological resistance*, which, per Burke (2012), describes an authentic belief that proposed change is wrong or ill-designed. Using this as a backdrop, my findings reveal that participant CMOs work through resistance of their physician colleagues with facts.

> *If you say stuff to physicians without data backing it up, and they do not believe what you say, you are hosed. You have got to have data. When you go to physicians, you have to have data to back up what it is that you say. Otherwise, they are not going to believe you (Dr. Wolfe).*

The other type of resistance experienced by my participants is *counterbalance resistance*. Per Swanson and Holton (2009), counterbalance resistance is used to stem the influence of poorly developed directives. In situations where an administrative initiative fails to consider all sides and voices, resistance is felt to be a "check-and-balance system" (p. 320). This type of resistance underlines the importance of my participants listening to their physician colleagues regarding changes in patient care and safety issues and new clinical protocols. The participants were uniquely situated to be that counterbalance in protection of both the patients and the role of the physician as the expert in care.

> *As physicians, we know about physicians and physicians' behavior. From the way you come into this, you are always suspicious of what the administration is up to because the theory is that this is for profit, and it is not about patient care so much as it is money (Dr. Joseph).*

Role Development

The next theme that emerged from participant responses regards how they learned to do the job. The sub-categories highlight informal learning models and professional organizations as ways that participants developed in the CMO role. The sub-category discussing formal learning covers the experiences of my participants regarding the influence of graduate programs and leadership courses on their growth in the role.

The role development theme was created when asking participants about training for the CMO position as well as continuing education. One of the most profound responses from my participants was a lack of formal training models specific to the work they do. Thus, the CMOs in this study depended primarily on informal learning over formal learning paradigms.

> *I have not had any formal training for this position. I have attended a few leadership-type conferences or seminars just in general. Specifically, to be a CMO, I have not really had any formal training (Dr. Zwicke).*

Formal executive and leadership curricula, including MBAs and MHAs, provide business and leadership learning but, according to my participants, were incomplete for guiding the specific needs of CMOs as leaders working with two very distinct and strong groups. Thus, the findings disclose a dominance of mentorship and informal learning.

> *I was very fortunate because I had three staff chiefs that were very good. One of them was a physician, and that was probably my best mentoring because he and I*

could think together, and he wore the other hat as Chief Administrator (Dr. Joseph).

This section on role development will focus on my participants' dependency on informal learning, their use of professional organization tools, and the limitation of readily available and appropriate formal leadership curricula.

You know, a course where they may discuss the roles and situations that you are going to come into and meet some colleagues who have done it and could maybe give you pearls. I think that would be helpful (Dr. Wolfe).

Informal learning. According to Dr. Esser:

The informal route is one which relies on having a strong mentor (division CMO, for example) to help focus the less experienced physician executive. The other option is for an MHA/MBA, but will still need mentorship. Mentorship is the key regardless of the route taken (Dr. Esser).

The findings regarding training for the position reflected a strong reliance on informal and incidental learning to inform and develop participants' CMO role in the hospital system. The identification of informal learning, although a term not used by the participants, was found in just about every one of my participants' experiences. Most identified mentoring as the cornerstone of learning the position, and their experiences were like what they faced as medical students and residents. That is, they were guided and supported by senior medical students and/or physicians. Accordingly, using self-learning, mentorship, and networking was second nature and found to be a competent way to perform the job.

You know, before I took this position, I called my residency director from 20 years ago, who is now a chief medical officer in Phoenix. I called him and got his perspective (Dr. Ruda).

The term *incidental learning,* although not specifically identified by my participants, appeared to be folded into the informal learning experiences. Incidental learning was described by Marsick and Watkins (2001) as the result of an experience, task, and/or other learning process. The question regarding how my participants learned to do the job endeavored to bring out both informal (mentorship and self-directed) and incidental (occurrences of trial-and-error) learnings. The findings reflect, in terms of learning, that informal and incidental learning were tightly bound as my participants reached for whatever was available to help them in the job.

What resulted from an examination of training methods was that my participants, as adult learners, fell back upon prior learning structures to inform what they were supposed to do and how they were supposed to do it.

[Training] Nothing. It was all on-the-job training, to be honest. Coming out of Baylor residency program, you are already a pretty good utilizer because your entire job is to get the patients out as fast as you can. Otherwise, your list explodes and your life becomes a living hell. That is really where it starts (Dr. Esser).

Many felt okay with this manner of learning the job, but some were remiss that more formal learning was not available.

Training is on the job and can be very humbling. Learning to listen is crucial. To get physician staff on board with administrative projects designed to improve patient care is an art. I do think formal training could help the CMO but don't have the time to state what that would include (Dr. Wolfe).

Even those participants who received formal learning (e.g., MBA or executive leadership courses) felt such curricula was more for administrative credibility and fell short in helping to inform their role.

The MBA punches your ticket, so to speak, and gives you that credibility to pursue those types of positions now. I think it is something that is in vogue that we are seeing a lot more in healthcare (Dr. Provasi).

My findings lean significantly toward informal learning, which also includes incidental learning, as analogous to the CMOs' experiences. Although many of my participants had no choice but to default to informal learning practices, a few relied on guidance from professional physicians and hospital leadership associations. This is discussed next.

Professional organizations. My findings revealed another source of guidance informing my participants. Professional leadership organizations and societies exist to help with healthcare and physician leadership and were mentioned by my participants.

The professional organizations for chief medical officers [American College of Physician Executives and American College of Healthcare Executives] are more advocacy, education, and training for skillsets that are needed for CMOs. Setting

benchmarks and performance objectives is really going to be very specific to each health system (Dr. Provasi).

The professional associations provide training for physician leaders, in a general sense. At least the organizations attempt to tie formal training with incidental learning by providing classroom work with on-the-job experiences.

I have also taken courses with the American College of Physician Executives, ACPE, which is probably the largest and most popular physician training group. They spend quite a bit of resources and actually have affiliations now for their own MBA and MHA programs. That is predominantly where the classroom learning took place, and then the rest of the learning was more dynamic, on-the-job training (Dr. Esser).

Unfortunately, the participants who actively engaged offerings from the ACPE were few. In fact, most saw the professional organizations for physician leadership to be less about the practical work of CMOs. Therefore, the participants were left wanting programs or avenues to network for specific issues, challenges, and solutions related to their experiences.

First I would get some books, and second I would maybe go to a course if they have one (Dr. Wolfe).

This study's findings regarding guidance from professional organizations are limited. This may be due to the reality that the CMO position is in the early stages of its growth in current healthcare systems. It may also be that the volume of general physician executives not identified as CMOs is the primary focus of the organization and not

niche, or specific, executive healthcare/hospital positions. Nevertheless, the incorporation of some formal learning programs by organized physician leadership is experienced by my participants and discussed next.

Formal leadership curricula. My findings revealed that several of my participants obtained formal graduate degrees (e.g., MBA) or attended leadership workshops. Those who did felt that some guidance was helpful, especially for understanding the business of medicine as being crucial to the CMO position.

> *Just going out and getting an MBA as a physician does not necessarily prepare you for all the pieces of being a successful chief medical officer. It helps, especially regarding understanding and relating to the operations and financial workings of the organization, but it does not really solve some of the other relationship, cultural, and other things that one would be looking for (Dr. Elder).*

Other participants entered formal education as a way of both learning about the executive side of healthcare and networking with other CMOs. This provided camaraderie for a few of my participants in that they were not "on an island" regarding their position.

> *I did a healthcare MBA. I was going . . . there and interacting with a bunch of guys that were all docs and that were all CMOs, basically. That was kind of a neat environment (Dr. Davis).*

Overall, the findings were scarce regarding formal training for the CMO position. Although leadership curricula exist within graduate degrees and organizational workshops, they are limited in terms of impact on the experiences of my participants.

Those participants who engaged formal training by way of MBAs or other graduate degrees found them to be insightful, but they needed more for their specific position.

> *I tell people that what I learned in my MBA was not as much things I did not already know, it was structured to things I already knew: how to put it together, how to formulize it, how to think it through (Dr. Sprecher).*

Reflection. The role development theme encompasses the very heart of how my participants learn to do a good job. Because many of my participants felt lost when starting in their role as CMO, avenues to gain more knowledge were, and are, available to help them grow in the position. My findings, though, suggest that informal and incidental learning models are the primary pathways to getting good at the job.

Since my findings focus on informal and incidental learning as paramount to developing the CMO position, I sought out literature specific to this learning model. The literature is abundant on the topic of informal learning. Marsick and Watkins (2001) defined and provided a theoretical foundation for what this study's participants experienced on a regular basis.

Informal learning is defined as learning obtained outside of a structured or institution-driven curriculum (Marsick & Watkins, 2001). The informal approach to gaining knowledge is learner-controlled. This means that the subject matter, pace, and evaluation of what is learned rests with the individual experiencing, or wanting to experience, a certain context. The centrality, then, of what is learned depends on the context of the experience.

Incidental learning, a close sibling of informal learning, is described as on-the-job training. As with informal learning, incidental learning is context centric. It is the experiences collected within the context of the workplace that inform the learner. These experiences, whether positive or negative, are all part of how the learner is informed on how to do his or her job.

My findings coincide with the characteristics of informal and, by proxy, incidental learning. The definition of informal learning by Eraut (2000) provides a framework for the experiences of my participants when asked what they learned from a new or challenging experience on the job. The definition of informal learning is expansive and considers intentions, such as gaining knowledge without consciously planning to do so (Eraut, 2004). The experiences of my participants, though, reveal how they identify, reflect, and deliberately seek out training within the context of the job.

Identification of learning. The participants were well-educated individuals. All of them completed an undergraduate degree, then medical school, and finally a postgraduate residency in a medical specialty. They all understand the importance of continuing education in their respective medical fields. The findings, though, sought responses that drew out the identification of learning for a job that is somewhat removed from prior learning in medicine. Consequently, many of my participants were surprised at their responses when asked what they learned from a new or challenging experience.

> *I think that the other thing is that you kind of have to broaden your knowledge about the other aspects of healthcare systems operations and focus on the ones that you do not know anything about (Dr. Elder).*

All my respondents knew they were entering a learning-rich environment but welcomed it since they wanted to do what was right for the patient.

Deliberation on learning. Dr. Ruda noted the following:

> *I think I am still in the process of learning, so I think time will tell. To know how I am going to overcome these challenges, I have to face them, you know (Dr. Ruda).*

The statement by Dr. Ruda was echoed across the board from my respondents. Each one faced new and challenging situations, from dealing with physician behavior to introducing a new patient safety policy.

> *What I learned, number one, is that anytime you do anything like that [confront physician with high level of disruptive behavior], you want to cross your T's and dot your I's because that physician was on a zero-tolerance policy already (Dr. Esser).*

Each participant spent time reflecting on how they would have handled the situation differently, or better. They all felt very comfortable with self-critiquing.

> *[A challenge on the job] gave me some introspection as to, "Well, maybe I could have done that a little differently." So, I think seeing how other people operate, when to go hard at something, when to push on something, when not to push on something, and those sorts of things and the attitudes that people have are important to doing the job (Dr. Davis).*
>
> *Wow, when I first become one, my thoughts, of course, were much more toward administration. That is where I sort of made an error in judgment. I thought I*

had to do exactly what administration's goals were, and there would be pushback, for instance, from the physician staff about certain issues or whatnot (Dr. Wolfe).

The participants used self-reflection to get at the heart of a difficult issue, and then engaged a new way of thinking about and responding to the issue.

You know […] miscommunication is the key factor that I see in a lot of these situations. Just simple miscommunication, and, you know, speaking with people, and talking to them in depth, usually you can get to the bottom of these problems (Dr. Wolfe).

Seeking out training. Since all my participants experienced new and challenging issues, they were not meek when it came to asking for help. There were situations they encountered that, during reflection, motivated them to look for guidance. Eraut (2004) called the motivation to plan a goal-oriented learning experience *deliberative learning*. In contrast, my participants were most often in reactionary positions where learning is reactive in nature.

I was responding to things. It was always responding. If I was doing nothing but that, I could say, "Hey. Look, here is a problem. Let's take this on. Let's do a process, and we can make this better." Instead, I was so far behind because of all my other work that a problem would come up, and I would have to put the fire out. So, I could not be as proactive about those sorts of things (Dr. Davis).

As noted by Dr. Davis, participants spent so much time reacting, it left little time for deliberative learning. Thus, some of my participants had to create time in their day or else they would rarely get the chance to grow outside of the situation.

> *I decided not to do that [get an MBA], but I have about 150 credit hours of leadership training with them in positions in management, healthcare law, healthcare finance, conflict management, negotiation skills, quality, and things like that (Dr. Provasi).*

Overall, the experiences of my participants fit with the descriptions found within informal and incidental learning structures. The heavy dependency on mentors, self-directed learning, and on-the-job training give some of them the feeling that more could be done. Dr. Wolfe bluntly stated:

> *There are no books. I will be honest with you, sometimes I wonder if the organization is not spending the money wisely on this position. It is not about me; it is just about if they are really getting their money's worth out of it. I think that is a legitimate thing, especially as dollars tighten in healthcare (Dr. Wolfe).*

Summary of Section

The first section of this chapter focused on the themes that arose from the responses of my participants. Their experiences, when collated through the crucible of my analysis created three themes: role ambiguity, role credibility, and role development. Each of the themes had sub-categories that highlighted the relevant substance through direct participant quotes. In this way, the themes are solely owned by my cohort.

A reflection of each theme was provided that installed theories discovered during the analysis. The theories were used to anchor and give weight to the responses. Each theory was introduced and discussed using direct quotes from my participants. The result is a deeper meaning of my findings as they connect to assumptions found in established theory and research. The next section presents the relationships discovered between the three themes. Even though each theme had its own set of nestled findings, they are connected in a new and profound way. These are discussed next.

Thematic Relationships

The themes described in the prior section do not exist as silos. They are part of a larger dynamic that builds the picture of what my participants have experienced as physician leaders. This section reviews the relationships between these themes gleaned from the experiences of the participants. Figure 1 adds a visual model depicting the relationships between the themes. In Figure 1, sub-themes support each theme. As noted in the model, relationships exist among the themes/sub-themes. These relationships culminate in a central connection that is revealed. First, though, I discuss the connection between the themes as noted in the model then discuss the connections, highlighting the complexity of the CMO position.

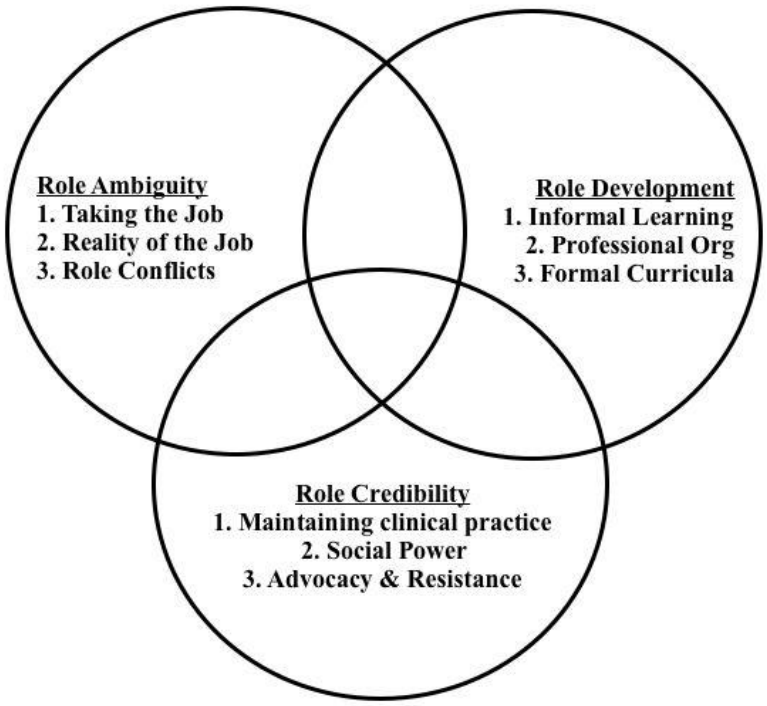

Figure 1. Relationships among the three primary themes.

Role Ambiguity and Role Credibility

The prior section revealed the impact of role ambiguity on my CMO participants. Each one had to be content with how he or she sees him- or herself professionally and as part of the hospital's executive team. This produced several responses regarding their place in the hospital environment. Many of my participants defaulted to their roots as physicians first and administrators second, while a few transitioned completely into administrative roles. The reasoning for their personal decisions varied from person to person.

The findings revealed that my CMO participants struggled to clearly define their position. This left many of them to self-define the position based on prior assumptions

about the job and past experiences in leadership roles. Additionally, the ambiguity expressed by the participants when defining the role demarcated the credibility required to perform the job. Accordingly, the fundamental relationship is revealed by understanding ambiguity as a reality of the job, which then informs the credibility needed to excel in the position.

The importance of role credibility, then, was felt acutely by many of the participants as they were taxed with using their relations and influence with the medical staff to help leverage changes or advances in healthcare policy within their respective hospitals. Most of my participants fully embraced their role as advocates for physicians and patients. Because they were also administrators, they could influence their physician colleagues through appropriate and thoughtful changes affecting patient care.

Each participant CMO had personal experiences being both an advocate and a facilitator. Several of these experiences were positive, especially when affecting a patient care policy that helped promote healing and safety. The challenging experiences were considered pathways for either counterbalancing resistance felt to be protective of physicians as primarily patient advocates or working through inappropriate or cynical resistance. The core of their ability to affect change, whether positive or challenging, was predicated on how they were viewed by the medical staff.

The medical staff, per the CMO experiences, was very attentive to how the CMO defined his or her position. For example, if the CMO was continuing to practice his or her medical specialty and dealing with the day-to-day issues of patient care, he or she was more likely to capture the respect of his or her peers. On the other hand, if the CMO

left medical practice to take the administrative position full time, the medical staff colleagues thought of the CMO as on *the other side* and were less likely to respect the CMO position. Clearly, the relationship between how the CMO defines and practices the role has a direct effect on the credibility of the position. Ultimately, my participants found that recognizing credibility relative to their definition of the job helped them excel at it. Next, the relationship between credibility and development of the role is discussed.

Role Credibility and Role Development

The findings surrounding credibility of the CMO role involve (1) maintaining clinical practice, (2) the ability to draw on relationships to influence change and contend with resistance, and (3) the ability to advocate for the medical staff and patients. The mastery of these characteristics is not inherent in the training of physicians or physician leaders. Nevertheless, the necessity of mastering these elements is reflected in the experiences of my participants. The following discusses these components are fundamental to the relationship between the development and credibility of the CMO role.

As noted in the relationship between ambiguity and credibility, there is somewhat of a linear connection between how the CMO defines the position and the level of credibility experienced. Looking at the experiences of the CMOs from a development standpoint, there is also a linear relationship between how well the CMO creates and maintains credibility toward the models used to develop and learn the position. Many of the participants expressed the importance of mentoring as an informal learning model but also stated that such mentors continued to practice. Most stated that

learning to be a good advocate came from being a good clinician and understanding what their colleagues were experiencing.

The participants also stated that although formal learning curricula helped understand the business of medicine, it did little to help build the credibility to affect changes in the behaviors of their physician colleagues. The insights to help with the position instead came from networking with other CMOs at the same formal learning venue. Indeed, it was not the curricula within the MBA, MHA, or leadership workshops that affected how well they learned about advocacy and influence, but the informal discussion with peers that generated useful learning opportunities.

The connection between credibility and development of the role is directly created by how the CMOs engage informal learning models. In these models, most commonly mentorship, the participant CMOs discovered the core components of credibility among their physician peers. Ultimately, the ways that CMOs develop their position directly affects their motivation to continue clinical practice, use influence as power, and contend with physician resistance through advocacy. Next, I discuss the relationship between the development and ambiguity of the CMO position.

Role Development and Role Ambiguity

The findings regarding role development of the CMO position, as noted above, reveal a heavy dependence on informal learning models. These include primarily mentorship and on-the-job training. Mentoring in the CMO position, according to the participants, is very successful in helping them learn and grow in the job. On-the-job

training, according the participants, is the result of their experiences and helps them to make different and/or better decisions in the position.

The findings regarding role ambiguity, as noted above, disclose the challenges of defining the position and the realities of being two entities at once, a physician and an administrator. Also, noted above, the ambiguity of the position feeds the conflicting dichotomy of the position. Therefore, my participants routinely face a fundamental decision regarding who they are in the role, depending on the context of an issue or situation.

The connection between the ambiguity and the development of the CMO position is played out as my participants draw on how they learn to do the job. The position calls for my participants to define their performance, but the definition is attached to how they are taught to do the job. The support available through formal curricula and job descriptions is limited regarding the practically of the job (Appendix E). Interestingly, the relationship is strongest when mentors assist in the definition of the position and the idiosyncrasies of the role. The experiences on the job, then, become learning opportunities that further support or challenge how my participants do the job.

The next section displays the affiliation between the themes and their relationships, and how my participants know that they are doing a good job. The question to the participants concerning how they appraised their work revealed experiences with formal and/or informal performance evaluations. These experiences are used to fortify the connection found between the role ambiguity, credibility, and

development themes and the performance of the CMO and accomplishing the shared goals of the healthcare system.

Themes and Job Performance

The themes revealed in the first section of this chapter connect and culminate in the performance of my CMO participants. The relationship discussion in the second chapter section creates a gestalt relative to the essence of why my participants define the job, why they do the job, and how they learn the job. This chapter section displays first, a performance model (Figure 2) depicting the work of my CMO participants in a constant state of translation, advocacy, alignment, and protection in support of the shared goals of the hospital. Second, the connection between the themes and the CMO performance characteristics is presented and discussed (Figure 3). The participants' responses are embedded in the discussions to reflect their ownership of the findings.

The Performance Model

> *It is a business, and we have to understand how to work within that environment. So, I have to make sure that doctors understand that. On the administrative side, if I feel like there is something really important for delivery of patient care, I need to be able to communicate that (Dr. Provasi).*

The performance model, presented in Figure 2, displays the work process of CMOs and the primary directive of their job.

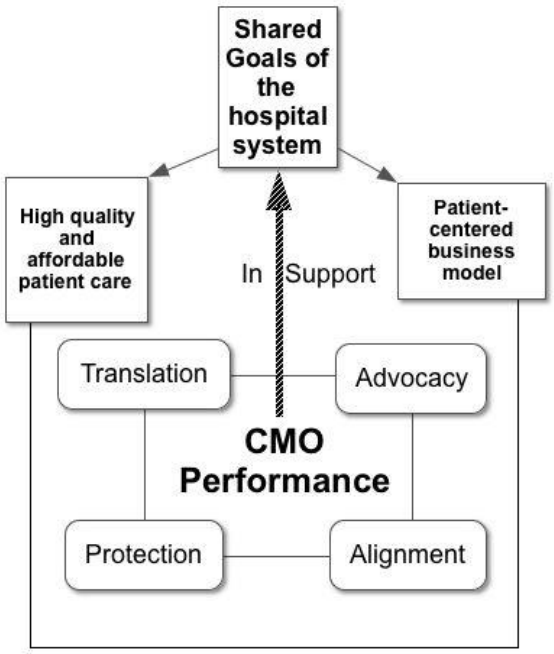

Figure 2. Performance characteristics informing CMO practice.

The characteristics noted around CMO performance represent four process activities that emerged from the analysis of the responses. The identification of the shared goals of the hospital system are presented in documentation regarding the CMO position from two healthcare system hospitals. I first discuss the shared goals phenomenon as central to the motivation of my participants. Second, I present the performance characteristics using participant responses.

Shared goals. The use of shared goals in healthcare is well established (Lee & Cosgrove, 2014). For the medical staff and administrators to converge on a common cause, it is vital to define what the goals are. The healthcare system is in the business of taking care of patients. The best way to grow the system is to offer high-quality and cost-conscious care. The core goal of physicians is finding the best way to care for their

patients. Together, the healthcare system and the physicians affiliated with the system share the goals of providing the best care for the most efficient cost.

The documentation provided includes job descriptions for the CMO and vice president of medical operations (VPMO; the role of VPMO, according to my participants, is the same as that of CMO). The complete job descriptions are provided in Appendix E.

The goals are outlined for both hospitals and support the statements provided in the CMO performance model (Figure 2).

The work of my CMO participants within the hospitals supports the shared goals of both types of employees of the hospital. Several participants noted the desire to meet the mission of the hospital though strategic thinking.

> *So, then my job as a CMO is to look at that [strategic plan] and decide, okay, I have to improve efficiency and quality. How am I going to do that? What programs am I going to initiate (Dr. Davis)?*

The need to align with the goals of the hospital, and thus healthcare system, is not just the purview of the CMO, it is also the motivation of the medical staff.

> *I think most docs that have been anywhere in one place know that the docs are really the ones that control the quality of the care. I think that from a doc perspective that applies to the CMO also (Dr. Davis).*

Other participants clearly understand the need to build cost savings into the care of patients for creating and maintaining solvency. If the hospital is struggling to meet its margins, patients will ultimately suffer. The work of my participants includes helping

the medical staff understand the importance of quality care over variations in individual care.

> *If you do not make your margin, you are not going to be able to accomplish your mission of caring for patients, so we still have to make sure we provide high-valued care and make sure we give high quality at the lowest cost possible so that we can make our margin and that we are in a quality environment now where the focus is on quality patient care (Dr. Provasi).*

Ultimately, the shared goals, what is important to both the hospital/healthcare system and the physician, provide a convergence of cultures for the greater good of the patient. The fundamental job of my participants is to build in a mindset that places the patient in front of personalities and group differences. Next, I discuss the primary work processes involved in CMO performance as the catalyst to achieving a shared goal mentality.

CMO performance characteristics. The performance types noted in the model (Figure 2) represent work processes that arose from the interviews. The naming of the processes is from the participants and used by them to build a contextual framework for what they do on a routine basis. Importantly, these characteristics are pertinent to their understanding of the purpose and motivation toward the job. I discuss below each performance type, anchored by the responses of my CMO participants, beginning with translation.

Translation. Several of the CMO participants, when asked how they described their role within the hospital, saw themselves as translators of both medical and business

speak. On the surface, translation between physician colleagues and administrators is straightforward.

> *I see myself as a physician-administrator. I am able to have conversations and a level of understanding around clinical care, and I am able to translate that back and work with business and operations folks, chief financial officers, etc. (Dr. Elder).*

Looking deeper, though, the challenges of resistance and cynicism on the side of physicians are revealed as my participants attempt to wield influential power and affect change. Consequently, translating to the medical staff is also connected with the other characteristics as a form of advocacy, alignment, and protection of the medical staff and patients.

Speaking administrative-ese is not always the easiest way to create understanding. However, my participants translate the shared goals into physician-speak so that the terminology and meaning of the goals are understood and accepted by a different culture. The process, then, for my participants is realizing that the elemental languages are different.

> *I will help translate, obviously, whatever administration is trying to get across. What is interesting is that administrators speak in a certain way, and sometimes it does not make much sense to physicians. My job is to sort of dumb it down so they understand exactly what the heck they are talking about (Dr. Esser).*

Advocacy. My participants used advocacy, as noted in prior sections, to help establish their definition of the CMO role and credibility among their peers. As a

performance characteristic, engaging advocacy is another way of defining and resolving resistance. My participants advocate for their physician colleagues and patients by maintaining what doctors are best at, taking care of patients.

> *I see myself as an advocate for the clinical side within the administrative realm, but I also see myself as basically the subject matter expert for the administrative side to bring the validity of the business side to the actual taking care of patients (Dr. Provasi).*

The connection with the other characteristics finds advocacy fostering alignment of the medical staff with the goals of the hospital/system. The link to protection is noted in how my participants recognize and counterbalance resistance. In this way, CMOs protect the medical staff and patients from poorly thought-out policies or policies that threaten patient care and overburden physicians.

> *If there was a situation where I felt we were compromising patient care, and it required an investment that I could not clearly delineate a return on investment, I would still fight for it on the administrative side (Dr. Provasi).*

Alignment. The ability to pull physicians through the changes in healthcare and, more specifically, the evolving policies and procedure of the hospital is daunting at best. For example, a healthcare system in Texas has a strategic goal for alignment (Figure 3). The model is a pyramid depicting a ground-up approach to managing the system's patient population through service lines directing performance, a sense of the system, and strategic growth. Physician alignment is within performance, and my participants are taxed with facilitating alignment to meet the shared goals of the system.

The alignment characteristic, as part of the CMO performance model, engages advocacy for their peers and translates the language to align the goals of the medical staff with the goals of the hospital. The alignment strategy guides my participants toward a more complete picture of the system and hospital's needs.

Figure 3. The CHI physician alignment strategy and its impact on system-ness and growth. From *Strategic Overview*, by M. Covert, 2016, paper presented at the CHI St. Luke's Health—Texas Division Service Line Retreat, Houston, TX. Copyright 2016 by Michael Covert. Reprinted with permission (Covert, 2016).

The CMOs in my study felt that an alignment strategy was appropriate and ultimately a road for a more interdependent team model focused on quality patient care.

I felt the only way we could have real, true improvement in healthcare delivery systems is if we have a closer coordination of thinking and alignment between the

clinical side and the administrative side. So, there has to be better coordination of, or better teamwork might be a way of saying that (Dr. Ruda).

Protection. The final characteristic is protecting the needs of the patient through the protection of the medical staff. My participants viewed the shared goals as only obtainable by safeguarding the essence of the physician culture, the diagnosis and treatment of disease, and the alleviation of patient suffering. By guarding this sacred oath, the CMO has a starting point for translating to the administration, advocating for variability in patient care, and aligning the medical staff to the hospital mission and goals.

Most providers want to be in a high-quality place where they know their work is valued. Most physicians, if you sit down and allow them to participate in the decision-making process of how they care for their patients, will not fight you. They will join you (Dr. Breimann).

My participants found it imperative that physicians must be able to practice their trade efficiently and to the best of their abilities. These processes were protected by the CMO being present at board meetings, committee hearings, and policy discussions. Many of my participants experienced wanting to protect physician practice and at the same time meet the goals of the hospital.

Physicians have behaviors that are ingrained in them for a purpose, and to ask them to change that, they have to forget that behavior and then be convinced this new one is going to be better. To tell a doctor that they do not know something is impossible. I mean, it is just not the way we are (Dr. Wolfe).

The Complete Model

The primary goals of the CMO position, as defined by my participants, are the care and protection of their patients through translation of cultural/group verbiage, advocacy for the needs of the medical staff, alignment of the medical staff toward a systematic mentality, and protection of the principal physician directive. The primary goals of the healthcare system and the hospitals within it are to provide high-quality and affordable patient care under a patient-centered business model. The work of bringing these goals together synergistically required my participants to define their job, recognize the importance of credibility to the position, and engage in all forms of development and learning available to the position.

The final part of this chapter section brings together the themes provided in the first section and the performance characteristics in the second chapter section. The complete model (Figure 4), which emerged from the analysis of the interviews, appears to draw a direct relationship between the two. The reasoning behind the connection may reflect how my participant CMOs experience the ambiguity, credibility, and development of their position coupled with how and why they perform the job. Ultimately, the model offers a visual depiction of the culminated experiences of my participants as CMOs within several hospitals as part of a larger healthcare system.

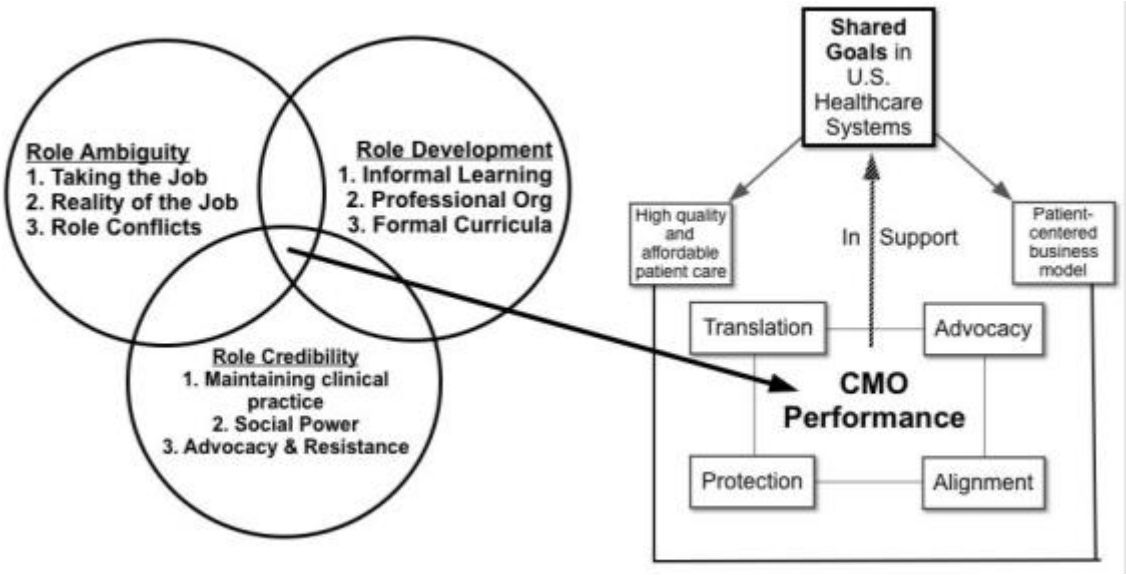

Figure 4. The direct connection between the CMO position and job performance of my participants.

Advising New CMOs

One of the most impressive findings that was not placed under a specific theme resulted from asking a simple question of my participants: What would you say to someone just starting out as a CMO? I believe this question revealed from my participants what they wish they had known prior to taking the job, how to affect change through challenges in the job, and what they envision the job to be in the future. A list of their responses is provided in Table 1.

The rationale for including the list of pearls of wisdom for new CMOs comes from the importance that my participants place on teaching and developing the position. Traditionally, physicians are bred to pass on their knowledge to medical students and residents. Consequently, offering advice for new and/or future CMOs comes naturally and provides a great source of insight based on firsthand experiences.

Table 1

Advice for New and/or Future CMOs Provided by the Participants

Participant	Response
Dr. Davis	I would say that as CMO you become an administrator, but do not stop being a doctor. I think that is probably the biggest thing.
Dr. Breimann	What I am looking for is—I will call it a leadership presence. I cannot define that, but it is a person that generates respect from others by their actions. It is everything from courteousness to responsiveness to friendliness to paying attention to the little things.
Dr. Elder	You must play the liaison role and bring information, bring up discussions, create relationships, build trust, then you can go from there.
Dr. Esser	The best piece of advice would probably be to go and do rounding on the floors every day. Round on the nurses and the physicians and get a feel of what their barometer is. Because that is what they are interested in. They are interested in seeing you up on the floor so that you have a pulse on what is going on.
Dr. Joseph	I think a Chief Medical Office should not be somebody fresh out of training anywhere because basically you need to have been in the trenches and understand many more of the facets of what makes a hospital successful, what makes it safe, makes good patient care, all that sort of thing. You have got to have some understanding for that. Communication is probably one of the most important things.
Dr. Provasi	I am more introverted than extroverted, and I prefer to listen more than talk, so it works well for me. I think it is important when you are interacting with physicians or administrative leaders, listening more than you talk is important and always understanding that there is usually a story behind the story. There is something that is driving a behavior or a process that may not be overtly evident initially that you need to try to dig a little deeper to find out about.
Dr. Sprecher	I think at the end of the day what you must do is you have to do your own homework on an issue as best you can, and you have to decide what looks right and what looks wrong, communicate the clinical side of the process, and just be firm about it. Do not get drawn into things just because they sound good.
Dr. Wolfe	Seeing patients gets done right, the relationships I have with my colleagues and the physicians, and the relationship that you can have with administration as well at the same point in time. It is a very difficult line to walk, but I think that you expand your relationships with so many people. At the same point in time, your relationships will change with most of your physician colleagues. They can certainly change.
Dr. Zwicke	I try to do what seems reasonable, common sense, and the logical thing to do. Like I said, it seems to me that 90% of the problems that arise just on a day-to-day basis are just miscommunications between groups or individuals or whatever, and improving lines of communication goes a long way in improving relationships.

Summary

Chapter IV presented the findings from my data collection and analysis. The sections provided in the chapter covered the themes discovered from the CMO participant responses, the relationship between the themes, and the connection of the themes to the performance characteristics of my CMO participants. An additional section offered advice for new and/or future CMOs in the words of the participants. The final section provided transparency regarding my researcher positionality and reflexivity when collecting and analyzing my data.

The thematic analysis of my CMO responses revealed three prominent areas as central to the CMO experience. These were role ambiguity, role credibility, and role development. Each was discussed using direct quotes from the participants and the researcher's interpretation of these responses. The themes were then compared to each other, revealing relationships that help to better understand the depth of the CMO position. CMO performance characteristics were provided and offer discernment of how the CMO work processes help support the shared goals of the healthcare system.

The themes do not exist separate from the performance characteristics. There is a strong connection between how my participants define their role and the way they perform it. This was discussed in order to reveal the intimacy of the thematic findings with the work characteristics and their support of the healthcare system mission and goals. An additional section concerning advice for the new or future CMO solidifies my participants' desires to further develop and grow the position not only for themselves but for those that follow.

Finally, positionality and reflexivity were discussed. It was important for me, as the researcher, to understand how I could approach my participants and gain their trust. This is pertinent for future research as well should other researchers look to duplicate or expand my work. My reflexivity offers transparency by revealing presumptions toward the finding and ways that prior experience and belief influence how the findings are displayed. Overall, this chapter provided a meaningful view inside the world of the CMOs of a selected system, which may translate across other healthcare systems. The next chapter presents the study's summary, implications, and conclusions, along with suggestions for future research.

CHAPTER V

SUMMARY OF STUDY, IMPLICATIONS, FUTURE RESEARCH, AND CONCLUSIONS

Introduction

This chapter ties the prior chapters together. A summary of the study is presented to show how the need to understand chief medical officers in the United States culminated in a review of prior related literature, a research design, and profound, surprising findings. This chapter is divided into sections that briefly display the components of the study and the resulting conclusion. The research findings support additional sections offering implication for research and practice as well as recommendations for future research. Research limitations are offered identifying shortfalls in my research along with reflections and suggestions to overcome them. Finally, my conclusions summarize the scope of the project.

Summary of the Study

This section provides a summary of the study. The brevity of the following subsections allows the reader to obtain a rapid synopsis of my project and connection to the findings. Central components of the study are briefly reviewed with emphasis on the findings. Additional subsections address assumptions and surprises found in the results.

Purpose and Research Questions

The purpose of this study, which used a qualitative methodology and design, was to explore the experiences of chief medical officers employed by a south western U.S.

healthcare system in their emerging role as physician leaders working with both the physician staff and hospital administrators. It was also the purpose of this study to discover and better understand issues faced by CMOs that affect their performance in this unique role. The primary research questions were:

- What are the experiences of CMOs as healthcare system hospital employees?
    - How do they define the role?
    - How do they succeed in the role?
    - How do they learn to perform the role?
- What are the primary issues faced by CMOs and how do these issues affect their ability to perform the CMO job?

The research purpose and questions anchored the entire project. I was interested in the fundamental experiences of my participants and used open-ended questions to begin the discovery process. As the result of using the noted questions, I found that my participants expressed a strong desire to better define and understand the CMO position, advocate for patients and colleagues, and play a part in the growing changes in U.S. healthcare strategy. The next section delves a little deeper into the significance of understanding the CMO position better and its impact to the future of patient care in the United States.

Study Significance

Understanding physician leaders and leadership is vital in regard to the performance of U.S. healthcare systems (Arroliga et al., 2014). Specifically, the work of the chief medical officers, as physician leaders living simultaneously in the

administrative and clinician worlds, is central to success during this time of unprecedented healthcare growth and policy changes (Kaissi, 2005). Prior to proceeding with the dissertation study, I contended that CMOs are in a tenuous, yet significant position, taxed with bringing together the business of medicine and the practice of medicine. Additionally, I believed that issues residing between the two worlds had to be identified and dealt with to move the U.S. healthcare system forward.

Interestingly, what I found was a lack of guides for the processes and issues confronting CMO practice. Furthermore, there were limitations toward understanding issues, such as the definition of, credibility in, and development of the position (Lee & Cosgrove, 2014; MacLeod, 2012), that continued to threaten an already widening chasm between leaders in healthcare. Significantly, unidentified and poorly defined differences in values and goals between hospital physicians and administrators were found to be important yet not completely explored (Cinaroglu, 2015). The identification of the noted significance of my study led to seeking out literature in support of my purpose.

Connecting Current Literature

Literature used to guide the emerging role of chief medical officers is offered in traditional leader-centered theories. These were found to be hierarchical and linear in nature, which led me to feel that alternative views of leading and leadership were not explored deeply enough regarding physicians. Thus, my literature review revealed only what was available to help understand the CMO position within a constrained set of theoretical frames and empirical works.

The approach to understanding the experiences of my participants prior to the data collection and analysis process included an exploration of an alternative approach toward understanding CMOs better. An alternative, process-centric tactic was contrasted with current empirical studies directed toward these physician leaders and CMOs using leader-centric models (Fernandez, 2003; Longnecker et al., 2007; Myers, 2013). What I found was the potential for something new regarding how my participants understand and practice their role.

The recent work by Gordon et al. (2015) supported my search for something new and different regarding the physician leader and leadership theory. They found that discrepancies existed in the application of traditional leadership paradigms to current healthcare systems. I used the points noted by this group to underline my belief and aid in the exploration of an alternative framework. Accordingly, this study, and other less profound articles, supported my work toward a deeper, more complete understanding of how CMOs perform their job.

Overall, my literature search, which used several key words across multiple databases, revealed little to help understand the experiences of my participants and/or guide CMO practice. The resulting collection of literature for my dissertation revealed scholarly journal articles, non-peer-reviewed trade journal articles, and commentaries dating back 15 years, but they were less than optimal for my project. In other words, my contemporary collection of works attempted but failed to provide robust guidance regarding the role of this unique physician leader. This realization led to the

development of a research design underlined by an exploratory methodology conducive to gaining a deeper knowledge of my participants.

Qualitative Case Study

The definition of a case study reveals a twofold perspective (Yin, 2013). The first is the desire to explore a real-world phenomenon bounded within a specific context. In this way, the case study allows for both to be examined for pertinence of what is desired to know. Additionally, Rowley (2002) stated that case studies can examine phenomenon in a new way when prior theory has been found inadequate. Thus, the case study method separates itself from other designs by enabling the study of both the specific interest of the researcher and the context concurrently in a way that is open to a new lens (Yin, 2013).

The second perspective considers the components of a case study. Yin (2013) discussed case studies as a focus on the unit of analysis guided by research questions and propositions that produce criteria-bounded interpretations. Yin (2013) also noted that characteristics of a case study support the inclusion of a guiding theoretical framework to bracket the varied types of case studies. For my dissertation study, an alternative theoretical framework was used as a different way to view the experiences of my participants.

Merriam and Tisdell (2015) pointed out that the most important characteristic is the definition of the case as an individual, object, or process within a bounded system. Furthermore, Merriam and Tisdell explained that if the researcher cannot recognize delimiters, such as a limited number of participants, observations, or data, then the

research cannot be considered a case study. I used the case study design since the role of CMO is bound by a specific context irrespective of healthcare system yet quite different from other physician leadership rolse.

Selecting the cases. My study aimed to explore and understand the role of CMOs in a specific healthcare system. The healthcare system I chose contains several CMOs reporting to their respective hospital system CEOs. Each hospital CMO is also connected to a divisional CMO. The rationale for using this particular healthcare system was based on both proximity and established networks with hospital leadership.

Selecting the sample. I selected physician leaders with the title of chief medical officer. The position had an assumed homogeneity, but I also examined job descriptions from hospitals within the system to determine if indeed the CMO position differed from position to position and hospital to hospital. I reviewed organizational structures since it was unknown if CMOs within the system were identified differently by locations of the hospital or system structure.

Collecting the data. Interviews were used to collect the in-depth experience of the participants. A personal, one-on-one dialogical approach allowed for relationships to develop between myself and the participants (Creswell, 2013; Merriam & Tisdell, 2015). I employed a semi-structured interview type for the dissertation. Hays and Singh (2011) defined semi-structured interviews as a "form of interview that uses a protocol as a guide and starting point for the interview experience" (p. 431). Table 2 provides a summary of the participants along with their time as CMO, medical practice background, age, and

temperament noted during the interview process. I used the background and temperament of my participants to help in the analysis and display of my findings.

Analyzing the data. The data analysis consisted of participant interviews and documents from the healthcare system hospitals. I relied on Creswell's (2013, 2014) suggestions regarding the analysis of my case study data. Creswell (2013) discussed the data analysis spiral, which recognizes the nonlinear process of collecting and analyzing data simultaneously. Consequently, the analysis became richer with each interview and document review. I used NVivo for Mac computer-aided qualitative data software, which allowed for the development of nodes, categories, and, finally, theme development. I display the findings from the analysis in a later section. Before the findings, though, I provide the ways that trustworthiness of my results was accomplished.

Table 2

Summary of Participants Including Demographics and Temperament

Name*	Years as CMO	Current Position	Med/Surg Background	Age Group	Temperament
Dr. Provasi	2	CMO (first interview)	Hospitalist	60s	Introvert; nonemotional; business-oriented
Dr. Davis	1	VPMA	ER Medicine	40s	Extrovert; talkative and animated; very open with responses and very comfortable during both interviews
Dr. Sprecher	1	Chief of OB/Gyn	OB/Gyn	50s	Gregarious; animated; noticeably frustrated
Dr. Ruda	<1	CMO	Family Practice	50s	Soft-spoken and deliberate
Dr. Zwicke	2	CMO	Ophthalmology	60s	Quiet, soft-spoken, meek, hesitant with questions about power and authority
Dr. Wolfe	2	CMO	ENT Surgery	50s	Animated; extroverted; crass at times and emotional
Dr. Esser	2	CMO	Hospitalist	40s	Straightforward, animated, thoughtful
Dr. Joseph	20+	Physician advisor to the CMO	Internal medicine & infectious disease	70s	Quiet, thoughtful, introverted, very knowledgeable
Dr. Endler	20+	CMO	Family medicine	60s	Lots of experience as CMO for different systems, straightforward, and knowledgeable
Dr. Breimann	4	CMO – competitor system	OB/Gyn	60s	Very animated, extroverted, knowledgeable, and supportive

* Pseudonyms were provided for each participant per the IRB protocol.

Actions toward trustworthiness of my results. Trustworthiness of the findings is a significant component of a research project (Merriam & Tisdell, 2015). The validation of the findings and reliability of the study instrument were based on my qualitative methodology. Table 3 displays the procedures I used to establish trustworthiness, authenticity, and credibility of findings. Each procedure is connected to actions taken, which allowed me to build relevance and trustworthiness of my findings.

Table 3

Procedures Fostering Validity and Reliability of Findings

Procedure	Action
Rich Descriptions	1. The primary themes resulted from a deep exploration of the experiences of the participants. 2. The experiences of the participants regarding how they define, develop, and perform the role were displayed such that chief medical officers in other healthcare systems might understand and agree with the findings.
Member Check	1. All conversations with the participants were recorded and transcribed. 2. Each participant was provided the transcript of their initial and follow-up interview and other correspondence relative to the study. 3. Each participant was given the opportunity to comment, add, subtract, and/or challenge the accuracy and interpretation of the transcript. 4. Any discrepancies were quickly addressed by the researcher and resubmitted to the participant for agreement.
Peer Review	1. A chief medical officer from another healthcare system reviewed the thematic analysis and findings. 2. Challenges and/or deficits noted in the findings were addressed by adjusting follow-up questions with research participants.
Adequate Engagement	1. A list of chief medical officers was secured from most hospitals as part of a south west U.S. healthcare system. 2. Nine CMOs were interviewed from the healthcare system hospitals and one peer reviewer was interviewed. 3. Each participant underwent an hour-long initial interview consisting of a list of unstructured interview questions. 4. Each participant was contacted regarding a follow-up interview. All except one participant underwent a second interview. Follow-up questions consisted of expanding on initial responses individually and addressing new questions that developed from common responses. 5. Three participants provided email follow-up responses after reviewing the preliminary thematic analysis and findings. 6. Saturation was claimed after a. No new information was discovered with follow-up interviews and emails. b. The primary themes were fully developed.
Reflective Journal	1. A reflective journal (Appendix D) provides chronological journey through the research process. 2. The thoughts of the researcher before, during, and after the research project offer a window into subjectivity, biases, and assumptions.

My Discoveries

This section displays the findings provided in more detail in Chapter IV. The discoveries resulting from the interview data and documentation analysis revealed a profound collection of themes and thematic relationships. Both the themes and their

relationships to each other offer robust insights regarding the experiences of my participants. The following tables provide an abbreviated view of the findings.

Summary of themes. The primary themes discovered during the analysis of the data are outlined and collated in Table 4. The core components and meanings of each theme are provided to guide the reader and provide a collation of the major findings. Each theme was developed through the analysis of the research data, which included the collective essence that each theme represents.

Each discovered theme in my finding was built upon a set of essential elements. For the role definition theme, participants found ambiguity and conflict within how the position was defined by themselves, their bosses, and their colleagues. Although defining the position was highly variable, the central component of the definition had to include the needs and protection of the patient as central to the goal of the job. After that, the definition had to involve protecting the physicians' job as healers. I found that each participant desired deeply to balance these goals with the needs of the hospitals that employed them.

Role credibility was vital to performing the CMO job. Building credibility was a challenge, though. Each participant had to contend with credibility, which was at the crux of their ability to influence physician colleagues through the changes in healthcare. To create and maintain credibility, most of my participants had to continue practicing their medical trade. For some though, continuing to practice medicine was not viable because the demands of the CMO position outweighed the ability to care for patients.

The development of the CMO position was quite a profound theme elicited from the participants. Even though I found my participants to be not only very intelligent but also resourceful, they hungered for training and development of the position. Many felt lost, leading them to seek out mentors as they had done when they were young physicians in training. Although this method of learning the role of CMO is not without merit and was professed by my participants to be successful, it should not be the only way to learn or develop the role. The noted themes do not exist alone, and the next section uncovers the relationships between them.

Summary of theme relationship. The themes listed in Table 4 were found to have relationships among each other. These relationships and the meanings behind them are listed in Table 5. Each relationship exists with core meanings that tie them together. As discussed in Chapter IV, the connections between the themes culminated in the crux of how the participants performed their job. Thus, the complete model of CMO practice (Figure 4) draws from the thematic relationships to build advocacy, translation, protection, and alignment toward the shared goals of the healthcare system.

Table 4

Summary of Themes

Theme	Essence
Role Definition	1. The participants continually worked through both the ambiguity of the position and the conflicting responsibilities as part of their role. 2. The essential job demanded working through the challenge of performing two roles, forced into one, by recognizing the most important thread woven throughout the hospital and healthcare system—the patient. 3. The participants, thus, kept the focus on the patient, not only for themselves as healers but for their colleagues and administrative counterparts as participants in that goal.
Role Credibility	1. The role credibility theme exposes the importance of CMOs as physicians who are still part of the fold, meaning the physician culture. 2. The reasons for continuing to be part of the physician in-group included being trusted as an advocate for their colleagues and patients. 3. To establish credibility among their peers, my participants had to maintain a semblance of medical practice.
Role Development	1. Role development encompasses the very heart of how my participants learn to do *a good job*. 2. Many of the participants felt lost when starting in the role as CMO although avenues were available to help them grow in the position. 3. The participants' experiences fit within definitions and assumptions found within informal and incidental learning structures. 4. The heavy dependency on mentors, self-directed learning, and on-the-job training gave the participants the feeling more could be accomplished by focusing on these areas.

As each theme had its own essential components, so does each relationship. The connection between role ambiguity and credibility is built upon how my participants first define and then enact the actions of the position. The definition of the role is also housed in each participant's own view and those of their colleagues. This led to a natural relationship wherein the participants could accomplish the goals of the position through influence. Interestingly, this influence was only to the extent that they were viewed by colleagues as continuing to understand the everyday struggles of the medical staff.

The relationship between role credibility and development is another connection brought out in the findings. The direct link between the two is found in how my participants learned to be CMOs. As noted in the role development theme, my participants relied heavily on mentors to guide and develop CMO performance. Since this is a common learning tool during medical training, credibility among physician colleagues was achieved with a sense of learning commonality. Importantly, my participants believed that their physician colleagues respected them as leaders due to them staying true to the informal learning models of medical practice and continuing to practice medicine to better develop the CMO position.

Finally, the connection between role development and ambiguity was found essential to defining and practicing the CMO position specific to job performance. It was vital for my participants to define first and then practice the job. The challenge was how to define and practice the role with limited formal learning support in a way that brings out the best performance. Instead, my participants were left with informal and incidental learning practices, such as on-the-job and mentoring, which left a modest amount of variability in definition and performance of the role.

Table 5

Summary of Thematic Analysis

Thematic Relationships	Essence
Role Ambiguity and Role Credibility	1. The medical staff (per the participants) was acutely aware of how the CMO defined their position. a. If the CMO was continuing to practice their medical specialty and dealing with the day-to-day issues of patient care, they were more likely to capture the respect of their peers. b. If the CMO left medical practice to take the administrative position full time, the medical staff colleagues thought of them as on the other side and less likely to respect the CMO position. 2. The relationship between how the CMO defines and practices the role has a direct effect on the credibility of the position.
Role Credibility and Role Development	1. There is a direct relationship between how well the CMO creates and maintains credibility toward the models used to develop and learn the position. 2. The participants expressed the importance of mentoring as an informal learning model but also stated that such mentors continued to practice. 3. The participants stated that learning to be a good advocate came from being a good clinician and understanding what their colleagues were experiencing. 4. Formal learning did little to affect, or improve, how the participants were viewed.
Role Development and Role Ambiguity	1. The CMO position calls for the participants to define their performance, but the definition is attached to how they are taught to do the job. 2. The support available through formal curricula and job descriptions is limited regarding the practicality of the job. 3. Experiences on the job, with or without mentors, become primary learning opportunities, which further support or challenge how the participants define and perform the job.

Revelations Discovered

My findings offered a window into the world of the chief medical officer through the experiences of my participants. I approached the research with a set of assumptions, an epistemological worldview, and a genuine desire to know the position, and those within it, better. I was excited to experience congruencies in and challenges toward what I thought would be found and what occurred. The following displays a few surprises experienced during the collection and analysis of my interviews.

Presumed theoretical framework. I began the research process assuming a specific theoretical model, relational leadership theory by Uhl-Bien (2006). The work of chief medical officers was believed to be a social process though which leading emerged as a collective effort. Thus, CMOs were thought to be creating an arena where physicians and colleagues could create and maintain interdependence, which moves U.S. healthcare forward. What I found only partially supported the relational theory. Instead, the bulk of the work processes experienced by my participants paralleled intergroup leadership by Pittinsky (2009).

Intergroup leadership literature by Pittinsky (2009) and Heifetz (1999) showed that leaders working between groups, but attached to one of the groups through culture and/or profession, act as translators and interpreters. This type of leadership appeared to be more closely related to the experiences of my participants. That is not to say that my participants failed to create and maintain interdependencies among physician peers and the hospital administrators. Instead, the terms *space*, *arena*, and *spheres of action* found in relational leadership theory (Crevani, 2015) were found to be too abstract as labels for my participants' experiences. Thus, my findings, which were expressed more pragmatically by my participants as intergroup-type behavior, caused the relational leadership model to become less concordant with and explanatory of the participants' experiences.

Hospital differences. The design for my research was a qualitative case study. Using this method was believed to show differences and similarities between hospital chief medical officers within a single healthcare system. I started by dividing the system

into two hospitals. What I found as I reached out to potential participants and later interviewed them was thatthe healthcare system that I used had several hospitals under its umbrella..

Interestingly, the variation and number of hospitals was not the revelation. Instead, the surprise was found in the variation of temperament and years of time as CMO of participants across the different hospitals. The experiences within the findings provided little distinction relative to the hospital of the participant. Additionally, the variation of hospitals, either large or small, had little connection to the experiences of the participants relative to the job. This appears to support using the role of the CMO as the context of my case study over the healthcare system or its hospitals.

Discovered themes. The analysis of the interview data coupled with the limited hospital CMO job description documentation percolated a set of themes that were surprising, especially considering the importance and impact of the job. My initial thoughts regarding how the participants might experience the role of CMO were marred in the discovery of potential work processes. Instead, the findings revealed a fundamental need by the participants to understand the position. Additionally, the participants were acutely aware of how their understanding of the position was viewed by their physician peers.

The findings also revealed that the CMO position is very underdeveloped. The experiences of the participants supported the lack of literature to guide the position but also brought to light the resilience of the participants. Each CMO that I interviewed had to both define the position in self-delineated terms and also seek out development and

learning of the position. Moreover, the participants' experiences displayed a strong desire to perform as well in the position of CMO as they do for their patients. I found this to be profound because it spoke to the depth of character of those who take on the CMO position.

Performance mismatch. The themes and their relationships to each other combined to form an emerging relationship with the performance behaviors discovered during the analysis of my data. Of interest was the mismatch of these proclaimed performance behaviors with those outlined in the job descriptions provided as documents in the study (Appendix E). For example, my participants discussed often the importance of the position relative to patient protection and ensuring quality care. The official descriptions call for directing patient issues towards the administrative collective. I found this to be concerning as issues of patient care ought to be the sole purvue of the CMO.

Additionally, the are of strategy and budget development noted in the job descriptions was not really a center piece of the role, as noted by the participants. Albiet each participant understood the importance of guiding the medical staff toward quality care with cost containment, most did not mention budget development or significant organizational strategy involvement. The mismatch was very evident by Dr. Wolfe, who noted during the initial interview and displayed in chapter IV, when he stated that most of performance measure on the official yearly administrative review of CMOs was not even relevent to the practicality of the job.

Overall, the surprises that arose through my research process are viewed as stepping stones for my implications and future research. There are opportunities for other theories, whether leader or process-oriented, that have been undiscovered yet might better explain the CMO role. Different healthcare systems and the CMOs within them may be facing the same challenges with defining, developing, and performing the position. Finally, more themes are likely to be discovered among U.S. CMOs by using different lenses and research questions.

Research Implications

The findings of this study constitute profound discoveries within the experiences of participants. The themes along with interrelationships provided a portal into the successes and challenges of chief medical officers in a large healthcare system. Literature found prior to and during the collection and analysis of the interviews offered insight regarding current research and guidance for practice. As such, this section offers implications within specific theories and practice areas as well as well as an overview of the implications concerning human resource development (HRD). Finally, I offer implications for future research.

Implications for Theory

At the start of this study, the theoretical framework was process-oriented, and I posited that it would anchor the understanding of CMO performance. Interestingly, the themes uncovered more than just a process orientation toward CMO practice. The themes also revealed additional theories not discussed in my literature review.

Table 6 provides a list of theories that were found to be related to the thematic findings during my data analysis. During my literature review, a multitude of leader-centric theories were uncovered to help explain the type and style of physician leaders in the United States. I began this dissertation by looking at physician leadership differently. During the analysis, I found more than just a solitary theoretical frame to explain the experiences of my participants. In fact, I found multiple theories to understand and guide CMO practice. Table 6 displays the theories I found that go beyond a solitary view of CMOs. The table lists the theory, the components of the theory that were focused on, the author(s) of the theory, and how my findings impact the theory.

The table has several notable features. First is the focus within each theory displayed. For example, organizational change theory is a very expansive theory with multiple components and assumptions. The analysis of my data emphasized resistance as the most dominant focus, though. For this reason, I centered on resistance because this is where my data led me. Another feature is the authors; all the noted theories have several influential authors, but the ones listed were central to my specific findings. The last item is the implications; each implication is affected by and potentially affects the foci of the noted theories. Thus, the implications lay the groundwork for future research.

Table 6

Implications for Theory

Theory	Focus	Author(s)	Theory Implication(s)
Role Theory	1. Role description 2. Role conflict	Katz & Kahn (1970, 1978), King & King (1990), Fisher (2001)	1. There is a practicality to the role of CMOs in everyday job performance. 2. The CMO position lives within a state of limited job standardization and is prone to the effects of social structures.
Intergroup Leadership Theory	1. Influence 2. Authority	Pittinsky (2009), Heifetz (1999), Hogg, van Knippenberg, & Rast (2013)	1. The way to move the healthcare system forward depends on the social and positional credibility of CMOs. 2. The power to get things done is heavily based on the CMO's ability to engender collaboration toward a common goal.
Organizational Change Theory	1. Ideological resistance 2. Counterbalance resistance	Swanson & Holton (2009), Burke (2012)	1. CMOs contend with change resistance routinely as medical practitioners and administrators. 2. The CMO position balances changes in healthcare by keeping patient care as the primary goal and influencing and advocating physicians as healers.
Learning Theory	1. Incidental 2. Informal 3. formal	Marsick & Watkins (2001), Eraut (2004)	1. Mentoring and on-the-job training are the primary learning activities. 2. CMOs seek out learning in order to perform by identifying, reflecting on, and seeking out learning opportunities. 3. CMOs use formal leadership curricula as part of a wide range of development tools.

Implications for Practice

As noted, the CMO position is guided by limited research, and the same is found regarding assistance toward practice. In my finding, several propositions for CMO practice were revealed regarding leadership, organizational change, and training. I display implications of my findings toward CMO practice in Table 7 to help the reader to visualize areas of practice that may be affected by my findings.

The table provides a succinct list of specific propositions revealed in the findings affecting leadership, organizational change, and learning. Each focus represents a larger umbrella under which CMO practice resides. Each implication, drawn from the findings, is associated to the focus in order to better understand the focus and its impact on the CMO position.

The most important part of Table 7 is how CMOs affect more than one practice area in U.S. healthcare. For example, working with resistance, which was found to be an essential component of CMO practice, is housed in the focus of organizational change. Since the actions taken (which underlie the results experienced) by my participants appear to encompass change resistance, the organizational change focus was the area most commonly affected.

Table 7

Implications for Practice

Focus	Practice Implication(s)
Leadership and leading	1. CMOs are not linear, hierarchical leaders and are not branded by style and type commonly found in leader behavior. 2. CMOs engage influence and authority within a social context surrounding a shared goal. 3. The ability of CMOs to move U.S. healthcare forward in the 21st century is based on the complexity of their credibility among physician peers and administration employers.
Organizational Change	1. Resistance to change is a primary issue facing CMOs in the United States. 2. CMOs routinely balance the needs of the patient and the needs of the healthcare system throughout the evolutionary changes in U.S. healthcare policies and directives. 3. The credibility of CMOs, central to managing resistance among physician peers, commonly finds them acting as translators, advocates, arrangers, and protectors of both physicians and their hospital employers.
Training and Development	1. The training and development of the CMO position is untapped and understudied. 2. The primary learning activity is mentoring and on-the-job training. 3. Formal leadership training offers much but is limited.

Implications for HRD

My dissertation focused on the themes and work processes discovered in the lived experiences of my participants. As a student of human resource development (HRD), the larger implications of my findings were viewed through the kaleidoscope of HRD research and practice. The following implications resulting from my research could easily be tied to the realm of HRD. The domains of HRD, which include organizational development, career development, training and development, and life-long learning (McLagan, 1989), are intertwined throughout my findings and closely tied to the theories and practice implications.

The implications for theory and practice, provided in Tables 6 and 7, offer connections covered extensively in HRD literature. Although learning and organizational change theories and practice share obvious associations with my research implications, the implications regarding role and leadership theory and leader and leadership practice are less apparent. As such, the follow provides a discussion regarding how my finding may impact HRD career and leadership development, which are two areas strongly associated with HRD.

Career implications. Career development, as a component of HRD, provides for a better understanding concerning the theoretical assumption of role development. The work of Super's (1980) life-span, life-space theory captures the essense of of how my participants must adjust and change as they grow to understand the role better. As an adult development theory, the assumptions found in Super's theory concerning role changes extends the concept that as the person changes so does the role (Swanson &

Holton, 2009). Eventually, the person matches their career to the combined realities of the role and their own self concept (Super, 1980).

In the same vein but from an organizational perspective is the work adjustment theory (Dawis & Lofquist, 1984). The assumptions of this change-centric theory reveals an exchange between employee and employer that is mutually beneficial and satisfying. As such, an expansion of role definition and organizational accommodations meet to build a relationship (Swanson & Holton, 2009). Change is required on both sides. My findings contend that the role of CMOs is in malleable, self-defined state that requires expansion of self-concept and assistance from the healthcare system in order meet the goals of patient care and system solvency.

Leaderhsip implications. The implications of my findings relative to leadership theory focus on intergroup leadership (Pittinsky, 2009) but this may offer only part of the story. Another theoretical area discussed extensively in HRD is leadership development, not only in terms of individual growth but organizational performance (Gilley, Eggland, & Gilley, 2002). My findings reveal that my participants have a strong desire to engage leader development in very basic ways. For example, learning to project a shared vision of the healthcare system to their clinician colleagues with credibility and trust.

The use of a shared vision, or purpose, to affect change is a hallmark of HRD leadership and change theories (Swanson & Holton, 2009). A shared goal, or goals, is vital to moving individuals, groups, and organizations toward a vision. My findings reveal the importance of directing CMO performance toward the shared goals of the

healthcare system. The performance model (Figure 2) finds that the behaviors of CMOs that emerged through the experiences of my participants are the catalysts to moving the medical staff toward the vision of the healthcare system.

My dissertation endevoured to better understand the role of CMOs. The findings, though, have little impact without a means to further research and practice the position. The work of HRD, in both research and practice, offers a wide scope of theories and strategies to help current and future CMOs perform the position better.

Future Research

The findings provided a plethora of implications for theory and practice. I offer a list of recommendations for future research based on the themes discovered during the analysis. Table 8 is a succinct list through which I diagram the impact of my themes on future research. As one of the most exciting parts of my dissertation, the implications for future research are a ready-made list to begin my postgraduate research journey.

The table consists of three parts: the theme, the focus, or foci, within the theme, and possible areas of research associated with the theme. The themes come from my data analysis, as noted in prior tables. The foci within the theme come from additional theory development and/or areas to build upon. The implication component comes directly from the findings and lists the deficits and/or limitations within the foci of each theme that could be expanded on or further developed. Most notably, the implications listed may appear to be offered in a general sense, but much can be developed within each one. Therefore, the future research implications are a list of launching points for my future research and practice life.

Table 8

Future Research

Theme	Focus	Future Research Implication(s)
Role Ambiguity	Social identity and conflict management	1. Further empirical research needed specific to the definition of the CMO position. 2. Additional empirical research and theory development needed to identify and guide CMOs working between two sets of role responsibilities and the effects on performance of the position.
Role Credibility	Power, influence, and resistance	1. Further research and theory development regarding influential power and authority in healthcare leaders. 2. Additional empirical research of CMOs as change agents and their contributions toward resistance management.
Role Development	Training and leadership development	1. Further research needed to better understand the strength and impact of mentorship and incidental learning within the CMO position. 2. Additional learning theory development specific to physician leadership in the United States.

Research Limitations

The limitations of my research are presents as essential to the transparency and credibility of my project (Roberts, 2010; Lund Research Ltd, 2012). The limitations offered in this section culminate a collection of issues that were either unpredictable or uncontrollable affecting my findings (Price & Murnan, 2004). This section displays the limitations of my project and is displayed in a way that identifies the limitation, explains the nature of the limitation, and how it might be overcome in future research.

The identification of limitation is important for both the author and the reader. Bringing to light the shortfalls of the research reflects the commitment of the author to be open and honest about the finding, or results (Brutus, S., Aguinis, H., & Wassmer, U., 2013). As such, the completion of my project reveals a number of limitations that affect the findings. The following discussed the prominent limitations and includes the nature

of the limitation and possible ways to overcome them in future research. These are included under the headings of methodological and researcher limitations.

Methodological Limitations

The set of limitations include methodological decisions, whether qualitative vs. quatitative design, or the mechanics of the design including sampling, data collection, analysis, and presentation of findings. For my project, the most blaring limitations include (a) being a novice at using a case study design, (b) small sample size in a single healthcare system, and (c) limitations of investigating one side of a two-sided system.

Experience with case studies. Athough I have written papers as part of a graduate program, the depth and breadth of conducting dissertation research is by far the most time and work intensive. As I review the methodology and design for my profect, it is important to keep in mind that what I was looking for and what I found regarding the purpose of the project dictated the design. The limitations of using a case study design for my project meant that I need to use context as the centerpiece.

I made initial decisions, after using a wide-angled approach to my questioning relative to a specific theoretical framework, but quickly found that my respondents were unable, or not in frame of mind, to answer questions concerning the specifics of my initial theory (Appendix D, pg. 2). This resulted in continuing to shift my theoretical framework to match the response level of my participants. This may not have been the right approach since I believed my participants were functioning in an assumed manner. As such, my approach using a case study may not have fully capitalized on context of the role as the best way to understand CMOs and how they perform their work.

I overcame this limitation by shifting the context of my case study to focus more on the role of CMOs over the physical location where the role is performed. In the future though, I would spend more time defining the context of the case, which would allow for more depth of my questions and, likely, richer responses. Overall, my questions were perhaps too shallow to investigate further the depth of the findings.

Single healthcare system sample. The amount of participants in a qualitative study is not as important as the depth to which the data is obtained. In a case study design, even one participant is sufficient as long as the findings achieve the purpose of the project as it is defined (Yin, 2013). For my project, the number of participants was sufficient to obtain the data needed to achieve the research purpose. The limitation, though, was not the number of the participants per se but my insistence of using one healthcare system in a region that has several systems.

The investigation of CMOs in the hospitals of a solitary sytem was based more on the proximity of myself to the potential participants, both physically and through social networks. In other words, the hospitals within the healthcare system of the study were base based more on the ease of obtaining data over if this system had more to offer than any of the other ones in the region. As such, I may have allowed convenience to trump the depth and possible diversity of participant responses.

In the future, I plan to overcome this limitation by expanding the research premises beyond a single healthcare system. The findings, as discussed, are not bound to the context of the healthcare system or its hospital. As such, I would continue my research using the context of the role but adding multiple hospital healthsystems.

One-sided perspective. My research was concerned with the experiences of CMOs as they performed their role unique physician leaders. Using this group allowed for first-hand descriptions of the position, which culminated in findings supporting the purpose of my project. From one perspective, the focus on CMOs was the instrumental to getting the data needed to understand the context of the case study. On the other hand, obtaining data just from CMOs may not have provided the complete picture of the role.

The nature of this limitation is found in the narrow view of the role. Since my purpose was the sole experiences of the CMOs, I captured only their insider view and left the research incomplete from an outsiders perspective. The reasoning for focusing just on the experiences of a select group of CMOs in a single system, as noted, more for convenience than the researcher-imposed boundaries.

In the future, my research will expand to included outside views. It is especially important, when attempting to understand the uniqueness of the CMO position, to get a view, or perhaps multiple views. As such, more views of the CMO position, for example by the CEO or other corporate-level executive, would lend not only depth to the finding but add greater trustworthiness and appeal to a larger audience. Overall, my research finding captured significant depth that culminated in rich descriptions of the CMO role. The findings, though, would be greatly improved with the addition of experiences of the position from other stakeholders.

Researcher Limitations

The second group of limitations of the dissertation are my own as the researcher of the project. The researcher's ability and experience working with participants in a

qualitative study is vital to overcoming a common weakness of this methodology (Anderson, 2010). As such, the research limitations of my dissertation include (a) inexperience as the human instrument and (b) my personal biases and assumptions encounted during the project.

Being an instrument. The researcher, as the human instrument to gather and interpret data, is one of the hallmark characteristics of a qualitative study (Merriam & Tisdell, 2015). As noted in chapter III, being the instrument of the study has both advantages and disadvantages. For my study, I chose to be the instrument as it was felt to be the best way to obtain the data concening my research purpose and questions. As a novice researcher, there were short falls associated with my inexperience as an instrument.

The work of Peredaryenko and Krauss (2013) discuss the experiences of novice qualitative researchers as calibration of the human instrument. For my project, this meant looking honestly at my own assumptions and biases throughout the project using reflexivity. The limitation of this method, and ultimately a limitation for my project, concern the fact that reflexivity is still myself judging myself. As such, the nature of being a human instrument in any qualitative study is perpetually limited by the researcher's own self-appraisal.

In order to overcome this limitation in the future, my approach to qualitative projects as the human instrument would do well to include what Peredaryenk and Krauss (2013) call an *informant-centered view*. Such a view allows for the researcher to look beyond his, or her, own biases, or assumptions, to see the inquiry from the informants

vision. In doing so, I would be more empathetic toward the lived experiences of my informants as they view my project and not just how I see it.

Personal biases and assumptions. The recognition of my own biases and assumptions throughout the dissertation process is a section on its own. The importance of identifying and clearifying my biases and assumptions helps support the trustworthiness of my project. Although it was required as part of my dissertation, key points are summarized here as a way to express the nature and suggestions to overcome them in the future.

The nature of my research biases are found in the personal experiences I encountered as a clinician leader. It is not possible to separate researcher experience from the researcher's desire to know a person, situation, or phenomenon better (Lincoln & Guba, 1985). It is possible, though, to identify the lines drawn throughout the project that helps to delineate what are the beliefs of the researcher and what are the beliefs of the participants; here in lies the limitation of my project.

My research purpose and premise was to understand chief medical officers better. That was assuming they were understood before I chose the focus of my work. As a novice researcher, I had a concept of how I would display my findings but in reality, the findings were displayed according to what I felt was important. Even though, I took steps, such as member check, to ensure the findings were the beliefs of the participants, perhaps I was offering them to the audience through my lens.

In the future, I will reflect back on this work, as well as the references noted, to guide a more participant-centric approach to the display of the findings. My approach

may include engaging the participants' to rank the themes of importance instead of just agreeing to the findings. I would go further to include the participants' beliefs in the relationships and emerging models, which I did not do in this project. Overall, my biases and assumptions before, during, and after the completion of data collection, analysis, and display of the findings could have been more reflective of the participants over my own aims.

Conclusions

The chief medical officer position has proven to be instrumental in the progress of the U.S. healthcare system. My dissertation study findings propose that although the position is indispensable toward healthcare vitality, the experiences of CMOs are incompletely studied. Thus, the work processes affecting performance of the CMO position are poorly defined and developed. Thus, the means to standardize and evaluate the CMO position are overly variable and cloudy at best.

I studied the experiences of CMOs in several hospitals associated with a large regional healthcare system in the southcentral region of the U.S. By using a qualitative methodology and design, I sought to better understand not only why my participants sought to take the tenuous CMO position but how they managed the challenges of being a hybrid physician leader. The rich descriptions of my participants' work lives, coupled with an in-depth review of literature, offered a unique window into the evolving, yet challenging, component of 21st century U.S. healthcare.

My research endeavored to push the envelope of current literature regarding leadership and learning. In the process, I found a complexity of theories and theoretical

frameworks previously undiscovered regarding my participants. The revelations, noted as part of Chapter V, create a foundation for future research and practice guidelines that will undoubtedly move the CMO role in healthcare forward.

Finally, my personal interest in the evolution of patient care in the United States as both a clinician and leader provided the motivation to pursue and complete this research project. I have grown through the dissertation process and hope to have affected the lives of my participants. Additionally, I am optimistic that this study and future works in CMO leadership will continue to shed light and guide the profession in the dynamic world of healthcare.

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APPENDIX A

RESEARCH CONSENT FORM

Consent Form for Student Interviews

INTERVIEW CONSENT FORM
Chief Medical Officers as Cultural Bridges in U.S. Healthcare
Professor Michael Beyerlein, Ph.D.
Texas A&M University
Department of Education Administration & Human Resources

Purpose of Research The role of chief medical officer (CMO) in the hospital of U.S. healthcare systems is challenging. Our research endeavors to understand a particular component of your role as a hospital CMO. As such, our research purpose is to explore the experiences of CMOs, in two Texas healthcare system hospitals, in their emerging role as bridges across the physician/administrator cultural gap, using a qualitative methodology and design. Additionally, we wish to discover the behaviors used by CMOs, in the process of bridging, which create, strengthen, and capitalize on the connection between the two cultures. You are being asked to participate in this research because of your experience working between the physician and administrator cultures as a hospital CMO in a Texas healthcare system.

Specific Procedures The interview is designed to capture your experience and thoughts about the role of bridging between two cultures commonly embedding in U.S. hospitals. In a one-on-one situation with a member of our research team from the Human Resource Development (HRD) program, you will be asked, in the initial interview, a series of questions face-to-face in your office, or by way of computer-mediated communication and/or telephone. The follow up interview will be via telephone. Your ideas and perceptions will be captured by Dictaphone, taking notes, and, if needed, video (for example, Skype).

Duration of Participation The interview is expected to last 45 to 60 minutes. Follow up interviews are expected to be more focused lasting 20 to 30 minutes.

Risks Your risk from involvement in this study will be minimal, limited identification information is collected and will be stored and handled in a secure location. The interview questions do not address sensitive areas.

Benefits If you decide to be in this study, there will be no direct benefits. However, it is hoped that through your participation, researchers will get a better idea about how chief medical officers manage the role of bridging between physician colleagues and hospital administrator.

Compensation There is no compensation for participating in the interviews.

Confidentiality All data obtained from participants will be confidential. All interviews will be kept secure, and no one other than the primary investigator and assistant researcher listed below will have access to them with the exception of the departments at TAMU responsible for regulatory and research oversight. Your statements might appear in a research report and may be published but without any identifying information.

Information about you will be kept confidential to the extent permitted or required by law. People who have access to your information include the Principal Investigator and research study personnel. Representatives of regulatory agencies such as the Office of Human Research Protections (OHRP) and entities such as the Texas A&M University Human Subjects Protection Program may access your records to make sure that study is being run correctly and that information is collected properly.

IRB NUMBER: IRB2016-0262D
IRB APPROVAL DATE: 06/06/2016
IRB EXPIRATION DATE: 06/01/2017

Voluntary Nature of Participation You do not have to participate in this research project. If you agree to participate you can withdraw your participation at any time without penalty or skip any questions you do not wish to answer.

Contact Information If you have any questions about this research project, you can contact Professor Michael Beyerlein, Ph.D. at (979) 845-2716, Beyerlein@tamu.edu or research assistant, Joseph Hlavin MS PA-C, jhlavin@tamu.edu. For questions about your rights as a research participant, to provide input regarding research, or if you have questions, complaints, or concerns about the research, you may call the Texas A&M University Human Subjects Protection Program office by phone at 1-979-458-4067, toll free 1-855-795-8636, or by email at irb@tamu.edu

Photo/audio/video Recordings

_____ I give my permission for [photographs/audio/video recordings] to be made of me during my participation in this research study.

_____ I do not give my permission for [photographs/audio/video recordings] to be made of me during my participation in this research study.

Future Use The data collected from these interviews may be used in the future for related research studies. The previous statement regarding confidentiality still applies.

Documentation of Informed Consent
I have had the opportunity to read this consent form and have the research study explained. I have had the opportunity to ask questions about the research project and my questions have been answered. I am prepared to participate in the research project described above. I will receive a copy of this consent form after I sign it.

_____ _____
Participant's Signature Date

_____
Participant's Name

_____ _____
Researcher's Signature Date

☐ I consent to the use of this data for future use.

IRB NUMBER: IRB2016-0262D
IRB APPROVAL DATE: 06/06/2016
IRB EXPIRATION DATE: 06/01/2017

APPENDIX B

LETTERS OF APPROVAL

May 11, 2016

Texas A&M University Institutional Review Board
C/O Office of Research Compliance and Biosafety
750 Agronomy Rd. Suite 2701
TAMU 1186
College Station, Texas 77843-1186

To support the study of chief medical officers for his dissertation, we formally authorize Joseph Hlavin MS PA-C, graduate student at Texas A&M University, under the direction of Dr. Michael Beyelein, to conduct research at CHI St. Joseph Health for the study "Cultural bridging in United States healthcare: A qualitative case study of physician leaders in a Texas healthcare system". Mr. Hlavin is a PhD candidate in the Department of Educational Administration and Human Development in the College of Education.

The authorization allows Joseph Hlavin, or his supervising professor, to come to our facility between June 6th, 2016 and August 29th 2016 to conduct interviews with participating physician leaders. The researchers may conduct one 1-hour initial interview and at least one 30-minute follow up interview with agreeing participants for the purpose of exploring experiences of physician leaders working between the cultures of physician colleagues and administrators of the health center(s). The researchers will be provided the names and contact information of agreeing participants in order to schedule individual interviews.

Mr. Hlavin or Dr. Beyerlein will contact potential participants by way of phone calls and email, as well as through administrative personnel for scheduling of each participant. The agreeing participants will be provided with the list of questions to be asked during the interview and the project consent though email. The researchers will contact the participants after 2 business days to follow up and electronically collect the consent.

Mr. Hlavin or Dr. Beyerlein will work with the schedulers of each agreeing participant such that minimal interference in normal work activities is experienced. The researchers agree to provide my office with a copy of the Texas A&M University IRB-approved, stamped consent prior to scheduling interviews, and will also provide a copy of the study report upon approval and completion.
Please contact my office with any questions.

Signed,

Rick Napper
President and CEO, CHI St. Joseph Health

IRB NUMBER: IRB2016-0262D
IRB APPROVAL DATE: 06/06/2016
IRB EXPIRATION DATE: 06/01/2017

Texas A&M University Institutional Review Board
c/o Office of Research Compliance and Biosafety
750 Argronomy Rd. Suite 2701
TAMU 1186
College Station, Texas 77843-1186

To support the study of chief medical officers for his dissertation, we formally authorize Joseph Hlavin MS PA-C, graduate student at Texas A&M University, under the direction of Dr. Michael Beyelein, to conduct research at CHI St. Luke's Health System for the study "Cultural bridging in United States healthcare: A qualitative case study of physician leaders in a Texas healthcare system". Mr. Hlavin is a PhD candidate in the Department of Educational Administration and Human Development in the College of Education.

The authorization allows Joseph Hlavin, or his supervising professor, to come to our facility between June 6th, 2016 and August 29th 2016 to conduct interviews with participating physician leaders. The researchers may conduct one 1-hour initial interview and at least one 30-minute follow up interview with agreeing participants for the purpose of exploring experiences of physician leaders working between the cultures of physician colleagues and administrators of the health center(s). The researchers will be provided the names and contact information of agreeing participants in order to schedule individual interviews.

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Mr. Hlavin or Dr. Beyerlein will work with the schedulers of each agreeing participant such that minimal interference in normal work activities is experienced. The researchers agree to provide my office with a copy of the Texas A&M University IRB-approved, stamped consent prior to scheduling interviews, and will also provide a copy of the study report upon approval and completion.
Please contact my office with any questions.

Signed,

Stephen L. Moore, MD
Division SVP & Chief Medical Officer

IRB NUMBER: IRB2016-0262D
IRB APPROVAL DATE: 06/06/2016
IRB EXPIRATION DATE: 06/01/2017

APPENDIX C

INTERVIEW GUIDE

Introduction

The follow list of questions makes up the initial interview. The questions are placed in components that will help provide background, training, and relationship content within the context of your role as Chief Medical Officer and will be drawn exclusively from your experience. The final component allows for additional thoughts or experiences that you would like to share. There is no set time limit to our discussion but you should expect it to take about an hour.

This is an 'unstructured' interview. The interview questions are only a guide for our discussion and other questions will develop during the conversation. Each question is searching for a deeper understanding of your experiences. As such, each question is not presumptive and your response(s) is (are) open for additional discussion and/or expansion.

The consent form is included in this email. It is provided prior to the start of the interview and outlines the purpose of the research project, duration of participation, and other pertinent information. You have unlimited time to review prior to agreeing to the consent and any/all questions will be answered prior to proceeding. Please find below the questions to guide the interview.

Background

1. How did you become a CMO?
2. What interested you about the position?
3. Tell me about a 'great' day on the job. Be specific.
4. Tell me about a 'bad' day on the job. Be specific.

Training and Performance

1. Tell me how you got good at the job of CMO.
2. Who helped you?
3. How do you know that you are doing a "good" job?

Relationships

1. How do you see yourself as both a physician and administrator?
2. Describe the relationship between physicians and hospital administrators
3. How do you see your job as bringing physicians and administrators together?
4. How do you decrease negativity and promote positive relations between doctors and administration?
5. How do help physician colleagues through the changes in healthcare?

Closing

1. What advice would you share that will help me understand the challenges you face as a CMO and how you deal with them?
2. What advice would you give someone new to the position?
3. Is there anything else I should have asked AND/OR you like to share?

TAMU IRB # IRB2016-0262
APPROVED: 06/06/2016
EXPIRATION: 06/06/2017

APPENDIX D

REFLECTIVE JOURNAL

6/8/16
I am getting started on the next phase of the dissertation now that my IRB is done. I am excited and scared to begin my interviews. Potential challenges include:
1. my Dictaphone working
2. understanding the participants' responses at the time of the interview
3. coding while interviewing.

6/16/16
The first interview is done and some thoughts included:
1. I felt comfortable with the interview format and flow.
2. I am unsure if I was able to get the depth of data needed - I will review the transcript with my methodologist and chairman to see how to improve.
3. I will set up a working 'mind-map' to help keep me focused yet still allow for changes/shifts in thinking as the interviews questions and content evolve.

6/17/16
Reading Leadership-in-Practice by Raelin (2016), in an article by Carroll (Leadership as Identity), I find that studying leadership as action looks for the mundane and routine. It looks for the absence or presence of leadership in real-time. This is different from other leadership studies looking for extraordinary or unique occurrences. My work is interested in how leadership is practiced by CMOs. What do they experience in the everyday work of being two entities. They are truly in-between (both in-group and out-group); how does leadership, their charge, evolve or present in this space?

6/19/16
I am planning my second interview, which should occur on 6/21. I have a meeting with my methodologist and chairman tomorrow. I will make subtle changes to the interview to include depth of experience and the process of leading in the middle. My literature review of CMOs reflects their position as 'in the middle'.

6/21/16
I met with my methodologist and chairman yesterday to debrief after my first interview. The conversations were both enlightening and positive. I walked away from these reviews with a renewed interest and drive.

Several issues and adjustments were suggested. I plan to institute these changes in the next interview today with a current VPMA and prior CMO. I will submit an addendum to the IRB regarding the inclusion of VPMAs since their role is very similar to CMOs. This will provide a backup of participants in case I need them. Other issues revolve around the professional vs. personal offerings by the participants. This group is very 'professional' and 'scientific'. As physicians, they are less attached to 'personal', or emotional, parts of recollection (in my experience).

7/5/16
I am reading "Leadership-in-practice" by Raelin (2016) and "Crossing the divide" by Pittinsky (2009). I am learning more about the work of leading in the gap and the process of leading, which encompasses the 'emergence of leadership' in everyday processes. Process-oriented leadership is collective action from discursive, mutual, recurring, and evolving patterns (Carroll, 2009 in Raelin). Additionally, leadership does not exist prior to, e.g. individual leadership like transformational, but emerges during

the interaction with others playing a part. The process may use artifacts or identities to foster the emergence of leadership but it is not attached to one person in a linear fashion. As such, leading is done in a created space of problems or challenges.

This is very interesting as the CMO position is not linear, or as a leader-subordinate dyad. He/she is an intergroup leader that is tasked with creating the space for both cultures to create solutions.

7/8/16
I completed my third interview today in Livingston, TX with a relatively new CMO. Since I have been reading a lot about the process of emerging leadership (Raelin, 2016) and intergroup leadership (Pittinsky, 2009), I have been evolving my questions to 'test', or tease out, those type of experiences. I continue to be very interested in the process of living 'in-between' two cultures and finding out how the CMOs contend with this role. This is such an interesting endeavor since the leadership, and leader, guidance in literature is heavy on LMX but this is very different from LMX processes. The CMO is on the same footing, as a "leader", as the physicians and administrators he, or she, attempts to lead. Additionally, the CMO is right in the thick of an evolving interdependency that perhaps on the surface is recognized by both cultures but not really engrained yet.

My reading on 'superordinate' development in Pittinsky is interesting and may play a role. I have yet to see, or hear, that this is what CMOs are attempting to create as part of their role but perhaps I am missing subtle, or maybe blatant, clues that confirm that is what is happening. I will pay more attention to this in my next interview as well as f/u interviews.

7/13/16
I am reading the IGL work of Pittinsky (2009) and Pittinsky and Simon (2009) regarding positive intergroup relations and Two-dimensional model of IGL reflecting on the reduction of negative subgroup relations and promoting positive subgroup interdependencies. This seems pertinent to current experiences of CMOs (in-group, non-prototypical) as they try to bring physicians (in-group, prototypical) into the 'business of medicine'. I would like to include some initial and f/u questions regarding what processes CMOs use to promote positive interdependencies between Ph & Admin and how they decrease negativity. Also, I would like to know how they know they (CMOs) are doing a 'good' job; this relates back to the performance section of HRD.

7/14/16
Interviewed another participant this morning. One striking issue was 'performance'; how is that measured in this job? The other interesting issue was high performing healthcare organizations: how do they do it? Seems that those led by physician administrators, or those led by administration, had higher performance. This may fit with some of the literature review for the project. I need to review that. The final interesting thing was power: the CMO is given a leadership position but little authority to make change. I would like to f/u that up with my interviewed participants and add something to the current question bank.

7/16/16
I am reading more about 'coding' by Saldana (2013). He explains coding as building block to categories that then lead to themes -------> to concepts and theory. I continue to pull apart words and phrases in my interview transcripts and hope that I am doing it right. One of the primary issues I see is

'frustration'. CMOs are frustrated by desire to move both cultures forward yet do not have the "teeth" to make it happen. Perhaps this is by design by administration and I will inquire more about it.

7/17/16
I now have four interviews completed and one f/u interview. There is a lot of data to review! I am continuing to learn quite a bit about the CMO job and how difficult it is for these professionals to do their job. Out of the ones I have interviewed, only one is currently in the position and relatively new. I see the others as somewhat **'beaten down'** by the experience but I need to realize my own view here. I don't want to taint my research with my own thoughts or subjectivity. I will pay attention to this throughout my coding.

7/21/16
I came across this in one of my interviews: it was something that I said that may sum up what I am doing:

"It is to understand the experience of CMOs who live in this in-between world, between being a physician and being an administrator. how do they contend with that? What do they call it? What are their experiences, not only professional, but personal experiences with that position? That has never been studied. If you look at the literature, the literature is very individual-based. Transformational leaders make great leaders. This type of person is a great leader. If you are this type of CMO, you are going to be a great leader [but CMOs are not really transformational as described in literature].

There is no qualitative in-between work that shows really what you are doing as a process in leadership. How do you do what you do? That is the main drive for it, and this is just a cornerstone of my overall research desires. There is no way I could do a dissertation on all that. It is too much. This is just the starting place, understanding how you do your job."

I saw this as really the purpose of my work.

7/22/16
As I continue to code, I am noticing another prominent issue and will explore this: powerless leadership or leading. It seems that the CMO does more convincing than leading. How do you do convince when there is no authority? Further reading in Pittinsky (2009) reflects the change of culture is really loss of culture. I believe this resonates well with the physician culture that is suffering loss. This is something that the CMO is also experiencing personally but also amongst his/her colleagues. How do they contend with this? I need to add this to the question bank.

7/30/16
I have been reading more about coding - first and second cycle as noted by Saldana (2013). he states that it is not uncommon to feel confused about which subgroup of first cycle methods to use. I am going to start with exploratory and then fine tune it with re-coding and second cycle coding. So far, I have noted some categories emerging in the codes and will start to work on those after the next (forth) interview is coded. I have not scheduled any other follow ups but need to.

8/5/16
I have been spending more time reviewing different articles that have become more interesting as I have been coding. The work by Sonnenberg (2015) regarding the models of CMO functions and org

structure seem to be very pertinent to the responsibilities of the title. I will see how to f/u on some of these as processes within the interview questions. I am finishing the 4th interview and have a f/u to code. I have three f/u interviews and more first interviews to perform. I am not at saturation by any means, as noted by some of the coding that I am doing. I plan to start more categorical and thematic work after the next two or three primary interviews.

8/13/16 **(Theoretical transition)**
I am going between RLT and IGLT. As I continue to read and code my interviews, it is coming clear that IGLT might be more appropriate. It seems that what the CMO is doing is working between the two factions but also part of the in-group (physician) culture. I have also noticed that the call for the CMO position is an administration decision. **The business of medicine needs the physicians to 'get on board'**. As such, the CMO is chosen for their ability to work with colleagues. I am unsure of what theories or principles are available to guide CMO practice knowing this.

On the issue of 'power'. What power is available to the CMO to get directives and CEO vision(s) realized by the medical staff? What are the 'carrots or sticks' used? Talking with one participant, there are different kinds of power and I need to research this. I would also like to understand this better relative to one of the threads I see developing in my interviews.

8/24/16
I am going back over my chapter 2 as I will be submitting to the AHRD conference in March. I am noticing a lot of changes that need to be made from my proposal. As I have been reading more literature, as well as some books, on leadership and leading, I am finding interesting tracks that I would like to explore with my participants. One is the cultural loss with its base in organizational change. This could be very insightful regarding how CMOs reflect and perform the work of leading their colleagues through the new HC changes. I am also finding 'leadership without power', or non-linear models, regarding how the CMO leads to be interesting.

8/30/16
I am starting build threads from what I am hearing from my respondents. **The major ones are lack of direction on the job, defining their role as CMO, patient safety is central, communicating is key, and influencing is the most power they have.** I would also add that CMOs have the power to create links and bring people together. I still believe that the CMO job is relational meaning that how they build relationships, trust, credibility, and give voice to each group is the 'practice of leading'. I don't see that this has been explored enough. This may likely be the result of really not knowing how to define the profession.

9/11/16
I have been reading on structural dynamics by Robert Fritz. I was introduced to this by my chairman during a discussion we had recently. As we were talking about balance, which was one of the issues I saw coming forward - covertly - in my participants' responses, I began to feel the tension they were experiencing during their attempts to help their colleagues see the importance of changes in how care is delivered and paid for. This led me to see the CMO as in between two distinct 'elements'. Fritz (1996) states that **when there is a discrepancy between two elements (physicians focus on patient care and administrators focus on cost and solvency) surrounding a basis of similarity (quality/cost patient care), tension arises leading to action(s) that are undertaken to 'resolve' the tension. The**

questions are: what action(s)? Who fosters these actions? What tools are available to these individuals to bridge the tension(s) to resolution?

Using this model, I can see that the CMO must balance the needs of both in order for the overall system to be successful and move forward. My chairman and I also spoke about the Calder Mobile and how the CMO is the center point, or fulcrum, that adjusts/shifts to maintain the balance between physicians and administrators, or the care of patients with the cost of patient care. I do not believe this has been studied enough, or with empirical work that recognizes, or explores, this work from the perspective of the CMO. It is very difficult work that leads to short tenures and/or burnout. Additionally, this fits with the IGL, which I have been exploring. The IGL is the one that balances - connects - fosters action between two groups. In this way the CMO is the fulcrum. **The question then is how do you maintain this balance, content with tension(s), and create energy and movement toward resolution?**

Another issue that came up was **performance**. From the perspective of the CMO, performance is primarily an informal process. There is limited experience by my participants regarding a formal process that guides their performance. This is quite different from the performance measures/processes that are used in business. The business processes are fundamentally benchmarked, e.g. hitting a certain cost savings or percent of market expansion, where the physician world deals with real time results, which are reality based and much less structured. As the CMO, he/she is the balance between the objective/universal business performance model and the complexity of reality experienced by the physicians. As I am reading and understanding more, I am approaching my participants with questions that focus on 'balance' and 'performance'.

I am also seeing the gap in training and development. Although some of my participants have had formal learning in business and leadership, e.g. MBA or MHA, these are few and most rely on informal and incidental learning processes to guide their activities and responses to strategy goals and crisis. I have made this a part of my questioning and will continue to explore with f/us and initial interviewing.

As I am starting to categorize, or group, my codes, I want to state true to the premises of my dissertation. These include viewing the work of CMOs as a process and not as an individual, finding out what struggles and accomplishments they 'experience' as bridges, what metaphors come to the surface, and what do they use/how do they help facilitate resolution. Ultimately, my dissertation seeks to understand the work of CMOs in the CHI Texas system. My model, or models, will help my define and understand the findings, which I hope will further the work of CMOs and help them to understand what they do and how they do it.

9/20/16

I am starting to form 'trees' out of my nodes. I am finding this to be a little challenging to get started. This is likely from the shear amount of nodes/codes that I have. According to Bazeley and Jackson (2013), I have several options with NVivo to create and manage my nodes. The first is to just start looking at the list of nodes and see which ones are closely connected, or can be sub-codes of 'parent' nodes. I will start here and see how it goes.

I still have a few initial interviews to get done and completing follow ups. I am getting some saturation and my threads are becoming more clear. I made adjustments to the research questions such that I will be focusing on certain areas - those that seem to be resonating with other CMOs. Initially, I was

questioning to see 'what sticks' relative to my area of interest. Now, I am focusing on those answers that have stuck.

9/21/16
I am diving head-first into my analysis. I have started to feel a lot of redundancy in the answers to my questions. In the f/u interview yesterday, I was running out of things to discuss since it felt like most of the ground has been covered. One new topic/issue is work-life balance. I will put this under 'balance' but it is also connected to 'career'. It seems from the responses that the CMO position is a full-time job but must be kept part-time in order to maintain clinical practice, which leads to more credibility with their physician colleagues.

I am also struck by how **CMOs have to balance multiple dynamics.** In my f/u discussion yesterday with a participant, we covered some of this. He came up with a 'moving fulcrum'; I reworded this to be a 'dynamic fulcrum'. I will research this term and see what comes up. I like the 'mobile' model and it is becoming clearer as I continue my collection and analysis.

9/25/16
I am continuing to narrow my focus on these interviews and node analysis. I am also starting to group some 'themes' into sets. What I am noticing is that there are a lot of connections - like certain nodes are related to other nodes that are related to theory. I am going to contact NVivo to make sure that I am grouping and showing overlaps appropriately.

I have been emailing my chairman going over saturation. I am noticing a lot of redundancy and noted earlier but I am unsure of whether I am "hitting the ceiling". I think that until I am sure, I will continue to work on it and proceed with more interviews. One problem is that I am not able to get the rest of the CMOs within the STL system to commit. If I continue to struggle, I can either stop and keep my case analysis as it or push into another system such as BS&W to continue adding to my data collection. One of the things that would make BS&W good is the fact that their CMO locally has a lot of experience, which could help triangulate and support what I have been hearing from the other, less experienced CMOs.

9/29/16
I pushed a little harder to get the rest of my participants on the record and have had some luck. I was able to get a CMO that had been doing it a while to offer some rich insight. I have also secured a date to talk with the divisional CMO at CHI Texas. I will use this interview to get a wider perspective of what I am hearing from the local CMOs. I will put together a focused list of questions for him. I think this will be primarily about his experience and what behaviors he is seeing in his CMOs to work in-between.

9/30/16
I completed my first review of nodes and re-categorizing. I have come up with the **top 4 nodes**:
1. Business of medicine
2. Intergroup leadership
3. Career
4. Balance

<u>After those:</u>
Metaphor

T+D
Leading
Misc - this is a 'dumping station' for codes that don't fit or don't fit YET
Leadership as Process
Credibility and Communication
HRD
Power
Changing culture
Leadership as practice

I have a few more interviews and follow ups. I also have a meeting with the Division CMO; for that individual, I want to focus/narrow my questions in order to get a 'wider' view of his CMOs are experiencing and what behaviors are prominent. I will also ask him if he is willing to look over my developing themes for comment and/or agreement. I will also do this with my participant group for member checking.

It is pretty cool how each 'look' at the codes creates more thought and perhaps more re-shuffling of nodes, relationships, and categories. I guess this is what Lincoln and Guba (1984) see as continuous collection and processing of data as a parallel model.

10/15/16
I have completed all of my 'proposed' first interviews. I am continuing to develop nodes from the codes that I am seeing in the interviews. I am feeling overwhelmed now regarding what categories are developing. Glaser and Strauss (1967) state that when doing constant comparison of your data, there will be times when you feel overwhelmed and more confused. These are the times to stop and create a memo. So that is what I am doing.

I spent time with my methodologist and my chairman this past week. Both were very helpful as I continue to tighten the data - moving from inductive to deductive with each participant interaction (Merriam and Tisdell, 2016). I have also started to highlight the questions in each interview both the initial and the follow ups. This is helping me see if the questions are consistent and if one or two questions are creating 'outlier' responses that may need further exploration. I have now done this for all of the interviews but need to weed out and compare each question. This is 'stuff' that will not be seen in the dissertation but background work.

I am also to the stage where I need to get preliminary findings and a write up done. I can then send this to a 'stakeholder' and my last participant as a f/u. This will help secure saturation, which is vital to knowing that my work has appropriate depth and trustworthiness. I will work on getting my nodes squared away today, then start on the preliminary report. I also have two interviews still out there to code.

Currently, my working themes branch from the "tension" experienced by CMOs as in-between the business and practice of medicine. The over-arching goals of the HCS from the CMO standpoint is patient care and safety; every one of my participants stated the importance of protecting the patient and making sure that the business of medicine keeps this central to the mission of the hospital. The business side is 'value = (quality + outcomes)/ cost (Managed care online).

As such, it is imperative the I focus on what is being 'said' by my participants. I am feeling better now that I wrote some of this down.

10/16/16
I continue to fine tune my categories. I went back over all of the interviews - to date - and listed the questions, then grouped them together into 'themes'. This is helping me by making sure that I hit the areas that matched, or match, my dissertation research questions and purpose. I will continue going over them as I go back and review my data for the purpose of further fine tuning the categories. I have reduced my categories to:

1. Career Issues
    - Seen as the enemy
    - Administrative change
    - Ambiguous definition
2. Culture Clash
    - driving a common/shared goal
    - Cost of patient care
    - "needs of the patient come first"
    - Resistance to change - physicians
    - Lining everyone up
3. Credibility/authority
4. T+D

Still working on it. I expect these to change or become better defined. One of the things I am realizing is that I have to make decisions on what I am going to see as important - a lot of it is based on what the participants' are saying but also on what I know and what I am looking for. what a tight wire for me to really listen to what the participants' are saying but what I am seeing realative to my research purpose. It can feel very frustrating at times as I chop through the data

10/22/16
I obtained a peer-review yesterday. This was very insightful. What I did was ask him first what were the issues he was experiencing as CMO in a large Texas system - different from the one I am studying. I then provided an outline of my findings and questions to see if he agreed, disagreed, or could add questions that I did not think of. For the most part he was very forthcoming in his review. There were issues, such as making sure that I clearly define the 'CMO'; this meant that in large HC systems there may be multiple definitions of the position. Overall, though, the position is one of protector of patients and medical staff, as well as translator in both directions between med staff and admin. This particular system is 'physician-centric', meaning that the organizational structure lines up the CMO with the CEO in a dyadic structure at each system facility. This might make for a very interesting study in how this system does it compared to the one I am studying. Nevertheless, I learned a lot and was pleased with the feedback.

10/31/16
I have now reached saturation regarding the prominent themes in my research. I have sent these themes with explanations back to some of the participants in order to get their opinions and/or challenges. So far, they have agreed that these are the most pressing issues involved in the job as CMO. As such, I have updated my thematic headings to include: Role Ambiguity, Role Credibility, and Role Development. I created a Venn diagram to show central questions by expressed by the participants as

well as sub-categories of each theme. The endpoint of my themes culminates in what is called CMO Performance. The performance paradigm of CMO is housed within the shared goals of the HC system as expressed by the participants themselves. Performance is defined as the actions my participants take to label the essence of their work behaviors. These include translation of both clinical and administrative language, advocacy of shared goals, alignment of clinical staff, predominantly physicians, toward shared goals, and protection of the primary role of physician as healers.

Therefore the performance of CMOs is accomplished within a more complex set of directives than what can be gleaned from the official job descriptions provided by CHI Texas HS. Furthermore, the core questions that build the performance model are unique to this hybrid physician leader. As such, my findings draw out what is really going on with the CHI CMO role in a more realistic and practical manner.

Now the I have a more concise model for my findings, I am ready to begin drafting my chapter 4. Of course, I will continue to keep an open mind to evolving understandings and new discoveries as I work with the data to bring forward the voice of my participants. I am getting more excited as I go forward. I believe this work will lead to some very exciting work in the future.

APPENDIX E

JOB DESCRIPTIONS

Position Title: VP MEDICAL OPERATIONS

Job Code: 33701

FLSA Status: Exempt

POSITION SUMMARY

Will lead the hospital's continuing emphasis on high-value, safe patient care through oversight of all aspects of physician performance, quality and clinical integration. Specifically responsible to provide the clinical, operational, strategic, and cultural leadership necessary to deliver care that is high-value (cost, quality, and patient experience) across the continuum of care. Will achieve this through the implementation of key strategic and operational initiatives that move the organization through work that involves maximizing clinical operations; improving clinician alignment and satisfaction; and lead evidence-based programs, practices, and activities. Effectiveness of the new position will be reflected in outcome measures expressed in measures of quality of care, patient safety, improved efficiency, patient satisfaction and financial performance.

POSITION RESPONSIBILITES

1. Set strategic direction for the above mentioned areas, which includes planning and managing processes and services for these disciplines to meet BSLMC's current and future needs. Develop and integrate these plans and processes to support BSLMC's vision, mission, and strategies
2. Provide medical leadership oversight for the development of high quality, cost effective and integrated clinical programs within the hospital
3. Develop and foster effective collaboration between clinical departments, divisions, medical staff leadership, Faculty and other affiliated services to ensure an integrated approach to providing services, and fulfilling the hospital's clinical, research and educational goals
4. Establish medical director councils/clinical program leadership groups to conduct the work of clinical operations, clinical integration, and population health management. Collect and share group trend data on resource utilization and length-of-stay, and works with councils/groups to develop, implement, and monitor improvement plans
5. Active participation in the care coordination program including monitoring of the appropriateness of procedures, admissions, and utilization of resources
6. Provide leadership on all initiatives and concerns involving patient safety, quality, infection control and risk management and patient service, especially those related to physician issues
7. Influence and engage peers to support improvements and facilitate between clinical needs and resource requirements. Align metrics and improvement projects with the most important organizational goals
8. Ensure a robust peer review and credentialing process, emphasizing quality, safety, service and behavioral issues on the part of the medical staff are addressed fairly and in a timely fashion
9. Work collaboratively with hospital leadership, Baylor College of Medicine, and CHI St. Luke's Health System to develop and implement well-balanced clinical, academic and research programs designed to ensure operational and strategic success for BSLMC
10. Provide compliance and accreditation oversight for all institutional licensing agencies, working with the CHI St. Luke's Health Chief Responsibility Officer when appropriate
11. Advise BSLMC President, CHI St. Luke's Health's CMO and Joint Venture Board on all physician practice issues.
12. Partner with CHI St. Luke's Health Chief Quality Officer (CQO) to ensure high quality, cost effective patient care by utilizing and analyzing the data developed by the CQO to guide and counsel medical staff members with respect to structure, process, quality of care, patient outcomes, to develop, implement and monitor improvement plans

MINIMUM QUALIFICATIONS

Education and Licensure Required:
*Medical Doctor licensed to practice in the State of Texas

Minimum Experience:
*Ten (10) years of practice experience; peer recognition as a "doctor's doctor"; five (5) years medical staff leadership experience

Minimum Knowledge, Skills, and Abilties:
- Excellent organizational and verbal communication skills
- Excellent clinical and business skills
- Management skills suitable for a complex tertiary level patient care setting
- Knowledge in LEAN management techniques and regulatory readiness

Position Description
SENIOR VICE PRESIDENT/CMO

Summary:

As a valued member of the Senior Leadership team, the Chief Medical Officer (CMO) is responsible for providing insightful and dynamic leadership to both the general medical staff and key departments of the Health System.
The CMO works strategically with other members of the leadership team and elected medical staff to ensure that quality, patient safety initiatives, and clinician practices move forward to ensure the overall goals and mission of St. Joseph Health System. The CMO is the identified liaison for the medical staff across the facilities and is responsible for assuring effective working relationship between the organized medical staff and administration.

The CMO will serve as the leader of clinical quality innovation; which encompasses a comprehensive inter-disciplinary approach to achieve care delivery excellence throughout the patient care continuum that measurably improves quality, creates comprehensive, patient centered care experiences, and reduces healthcare costs by reducing waste and optimizing the value proposition. This is achieved through the effective alignment of people, process and technology that enables and supports rapid cycle tests of innovation leading to creative, effective solutions.

The CMO also serves as Physician Advisor in the case management and utilization management departments. These Physician Advisor services would include assisting the Hospital's case management department in dealing with patient status, concurrent denial on appeals, current case review conversations with other physicians and physician education. In particular, the Physician Advisor would be a permanent lead member on the utilization management committee to help identify, track and trend utilization issues by leading the Code 44 process and other related processes.
The Physician Advisor services would also include presenting the physician's viewpoint during reviews of Rapid Improvement Events processes, group physician education and providing leadership reinforcing the utilization goals of the Hospital.

Reporting Relationships:

The Senior Vice President/ CMO reports to the President and CEO of St. Joseph Health System and directly supervises the following positions:

- VP Quality/Patient Safety Office, who is responsible for Infection Control, Accreditation, Risk Management and Outcomes Management
- Director of Medical Staff

Qualifications:

A degree of Doctor of Medicine or of Osteopathic Medicine from an accredited and approved school of medicine, Board certified physician, with current state license or unencumbered eligibility for license issued by the Texas Board of Medicine.

A minimum of ten (10) years of clinical practice with demonstrated achievement; a minimum of three (3) years in hospital medical staff leadership or CMO experience in a similar size hospital system preferred.

Technologically proficient with a penchant for using technology tools, in the practice of Medicine and patient care as evidenced in the use of electronic medical records and other tools.

Strong analytical skills and experience in budgetary and operational management related to core services.

Demonstrated ability to gain medical staff support when developing, implementing, and promoting projects, ventures,

and programs in a highly matrixed-environment experience with the peer review process. A relationship builder and effective communicator across the organization to include medical staff, senior management, clinical leaders, staff, and patients.

Experiences building bridges between employed and non-employed physicians and between hospitals with results measured through patient, team member and physician satisfaction scores and related-action plans

Principal Accountabilities

1. Personal Leadership:
   Advances awareness of the mission of St.Joseph Health System and the integration of mission into the culture of the organization. Serves as a role model by demonstrating personal behavior reflective of the values of the organization. Positively represents St.Joseph (including the organization's leadership, clinical capabilities, team members, and community service) to others. Maintains business practices that are compliant with laws and regulations and promptly reports facts covering individual or organizational activities believed to be in violation of the law, regulations, or the Ethical and Religious Directives. Routinely participates in the organization's educational, communication, fund development, and social activities.

2. Organization Support:
   Maintains awareness of and compliance with organizational policies and administrative guidelines. Keeps supervisor and other relevant team members informed of developing issues or situations that have the potential to become more significant. Expends discretionary resources in a manner that supports the achievement of organizational goals. Promptly provides the necessary corrective action when unacceptable performance occurs. Takes personal responsibility to maintain the appearance of work and public areas in a neat and orderly fashion, prompt notifying the appropriate team member when assistance is required.

3. Customer Service:
   Willingly initiates action to meet the legitimate expectations of all customers. Responds to requests for assistance from Medical Staff leaders, Medical Directors, patients and team members in a helpful and timely manner. Maintains immediate accessibility during the workday and while on call. Demands high levels of customer service from other managerial team members and personally leads the improvement of customer satisfaction with services provided by areas of responsibility. Exercises personal initiative to improve satisfaction with hospital services by attending, procedural or referring physicians and to improve satisfaction with support services provided to physicians in their office.

4. Assigned Team Members:
   Ensures that new team members are screened, oriented, trained and mentored to effectively function in accordance with their job description during the first few years of employment with St.Joseph. Keeps all team members in assigned areas informed of key organizational and work group issues/events. Develops individual and group competence through in-service education and on-the-job training opportunities. Develops volunteers to augment employed staff and creates an environment that is conducive to those who volunteer their time in support of the mission. Recognizes employees, volunteers, and medical staff members for positive contributions. Ensures that effective and timely performance evaluations, including recommendations for improved performance, are provided for all team members.

5. Planning:
   Prepares operating budget for assigned areas to reflect an increase in value per patient served. Identifies opportunities to improve efficiency and budgets accordingly. Identifies contingency plans for unanticipated expenses and/or less than anticipated net revenue. Prioritizes capital requests based upon organizational goals, environmental safety and technology required for patient care.

6. Expense Management:
   Manages worked hours and direct expenses in assigned areas relative to applicable staffing standards and budgeted patient volume. Adjusts expenditures to net patient revenue to maintain budgeted operating margin. Ensures that charges are thoroughly and accurately entered on a daily basis. Routinely evaluates

and implements opportunities to improve efficiency.

7. Compliance Management:
   Maintains ongoing compliance with applicable federal and state laws, licensure, regulations, and corporate compliance requirements in areas of responsibility. Maintains ongoing compliance with accreditation standards in assigned areas of responsibility. Routinely monitors compliance to ensure continuous survey preparedness.

8. Performance Improvement:
   Actively participates in a leadership role in organizational performance improvement teams and initiatives. Within each area of responsibility, develops appropriate indicators of performance aligned with strategic objectives with targets that support achievement of excellent performance. Regularly monitors and reports progress of performance improvement activity.

9. Satisfaction Improvement:
   Actively participates in initiatives to improve patient satisfaction and physician satisfaction. Improves team member satisfaction in areas of responsibility. Personally manages prompt complaint follow-up and resolution maintaining contact with complainant until the issue is resolved.

10. Medical Direction Supervision:
    Supervises St.Joseph institutional medical directors and develops performance focused job descriptions/ contracts. Emphasizes quality improvement and physician satisfaction specific to each leader. Maintains routine and meaningful communication and periodic performance evaluation with each medical director.

11. Emergency Services Call/Trauma Services and Indigent Care Program
    Oversees the Emergency Services call and indigent care program. Ensures that coverage is in place to ensure compliance with programmatic services offered and also to maintain any designation (IE Level II trauma, Chest pain, Stroke) when required by government regulations or when economically appropriate.

12. Process Improvement Program
    Strategically advances process improvement of the organization as Chief Quality Officer. In collaboration with the VP of Quality/Patient Safety Officer, assures focus and discipline on the improvement of quality across the continuum with a significant focus on patient safety and high reliability organizational principles and practices. Directs efforts designed to improve publicly reported indicators and efficient resource utilization.

13. Organized Medical Staff Management
    Provides support for the Medical Staff leadership, and Medical Executive Committees. Educates Medical Staff leadership and the Medical Staff regarding administrative issues and current issues facing medicine Serves as an as an advisor on medical staff credentials issues for medical staff officers and departmental chairpersons, medical staff office, CEO, and the Boards of Trustees, as applicable.
    Serves as the liaison between SJHS and each of the individual hospitals' Medical Staff Executive Committee. Addressing opportunities related to quality outcomes and the efficient delivery of health care services. Develops appropriate professional, educational activities for medical staffs, hospital departments, and Boards of Trustees as needed or as assigned.
    Actively works with the medical staff officers to foster effective working relationship between the leaders of SJHS and members of the Medical Staff.
    Attends and represent SJHS at Medical Executive Committee meetings and appropriate medical departmental meetings of all entities including long-term facilities. Actively participates in the Ethics committees of SJRHC and rural hospitals/long-term care.
    Ensures compliance and quality of hospital-based physician groups (e.g., anesthesia, emergency medicine, hospitalists, pathology, imaging, neonatology and any other hospital-based medical services that may develop).

14. Clinical Integration Program
    Primary emphasis is on clinical quality improvement and cost reduction across the continuum of care utilizing IT integration to reduce individual practice variation. Secondary emphasis is on medical home development

and chronic disease management to reduce high cost/low margin hospital ER and inpatient utilization. Works collaboratively with the Chief Medical Office of Clinical Integration. Network to further the goals and requirements of the Accountable Care Organization and initiatives set out for Health Partners as it applies to acute care medical care and hand offs to the post-acute setting.

15. Physician Recruitment:
    Participates in short and long term physician succession planning in order to assure the strategic goals of the health system

16. Patient Safety
    In collaboration with the VP of Quality/Patient Safety, directs the patient safety program for the St. Joseph organization. Leads the development of a culture of patient safety among organizational leaders in both ambulatory and institutional settings. Develops ongoing performance improvement initiatives throughout the organization to improve the reportable levels achieved by St. Joseph. Ensures that adequate routine monitoring and reporting occurs to develop confidence in the program by governance.

17. Utilization Management
    Serves as physician advisor to case management and utilization management departments. Participates in patient issues such as status, concurrent denials on appeals, case review and physician education.

18. Medical Education:
    Serves as organizational contact for Texas A&M Health Science Center College of Medicine and related medical education programs, both graduate and undergraduate. Ensures students and residents are properly credentialed and supervised. Serves as organizational contact for affiliation agreements, clerkship and medical education agreements between TAMHSC and St Joseph affiliated physicians. Represents St Joseph as a member of the Graduate Medical Education Committee.

Goal Accomplishment:

Completes assigned personal goals. Routinely reviews progress with supervisor.